BRITISH COLUMBIA

Ref #: 256461
Date: June 2022

Summary: Child and Family Practice Review of the Death of a Youth in the Care of the Director in 2020

Circumstances of the Fatality

The review examined the practice related to a youth who died. The youth and their family were receiving guardianship and family support services at the time of the death.

Findings

The assessment and planning for the youth partially addressed their safety and well-being. The youth had a large care team that collaborated frequently to support their safety, even though the youth was reluctant to accept help. They had health issues that impacted their functioning and contributed to their inability to engage in services. There was no record of assessments that supported decision making and permanency planning.

The youth was involved with another ministry program, but this program did not assess the youth's mental health needs and did not provide service in accordance with policy. Additionally, the youth's consent was not obtained prior to providing this service, nor when sharing their personal information. The youth's electronic file information was not entered in a timely manner and there was no record of consultation with a supervisor.

Actions

The involved Service Delivery Areas (SDA) leadership and the Quality Assurance team developed an action plan for the involved teams to review the BC Permanency Framework and the Case Transfer and Joint Case Management directive, including collaboration on planning and coordination of services. A review would also occur of the SDA's provision of services to youth with a specific need regarding supervision, documentation, consultation, and consent.

The review was completed in December 2021. The above action plan was fully implemented in May 2022.