BRITISH COLUMBIA

Ref #: 254322
Date: June 2021

SUMMARY: FILE REVIEW
Of the Death of a Youth in the Care of the Director in 2020

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died. The youth received guardianship services at the time of the death.

Findings

The youth's needs were largely assessed and planned for throughout the period under review, although there were some delays about sharing information with a ministry program. The youth's placement addressed their safety and well-being. Further assessment and planning of a specific issue was required yet did not occur.

Actions

The involved Service Delivery Area leadership, Delegated Aboriginal Agency leadership and the Quality Assurance team developed an action plan to review: how to share and document specific assessments and document conversations; that when issues are identified a plan is created, the plan is documented and shared with those involved with the care of the child/youth; and relevant policies about sharing information when children/youth are at risk. Additionally, when protocols are developed and operationalized, information is communicated to staff in the Service Delivery Area, contracted residential resources and the Delegated Aboriginal Agency.

The review was completed in May 2021. The above action plan is due for full implementation in September 2021.