BRITISH COLUMBIA

Ref #: 247580
Date: June 2021

SUMMARY: FILE REVIEW
Of the Death & Critical Injury of Youth Known to the Director in 2019

Circumstances of the Fatality and Critical Injury

The review examined the case files of a youth who died and their sibling who was critically injured while in their parent's care. The youth and their family were receiving services at the time of the death and critical injury.

Findings

The director received several reports of concern about the youth in the months prior to the fatality. The director responded to these reports; however, did not complete all of the steps for the child protection response. The director did not corroborate information through collateral information checks, or thoroughly assess the youth's safety and well-being.

Upon learning of the youth's fatality, the director offered the youth's sibling and their family support services; however, the director did not assess the impact the youth's death had on the sibling's safety and well-being, particularly in relation to specific issues that had been raised prior to the youth's death. Additionally, Structured Decision Making tools were not completed in a timely manner.

Prior to the case review being finalized, the Service Delivery Area leadership engaged a community agency in a process to address the specific needs of all children and youth who access services through both the director and the agency in the future.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for the Director of Practice to review the case review report with the involved staff and discuss the use of Child Protection Response Policy.

The review was completed in March 2021. The above action plan was fully implemented in April 2021.