BRITISH COLUMBIA

Ref #: 247700
Date: December 2021

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

Circumstances of the Fatality

The review examined the ministry services provided to a youth who died. Although the director was not providing services to the youth and their family at the time of the death, they were on a waitlist for services.

Findings

The director did not properly assess the youth's safety or develop a plan for their well-being. The youth and their family were placed on a waitlist for services and were not contacted prior to the youth's death. There was also no collaboration between ministry programs regarding their mental health needs. The ministry program referred the youth to another community support program; however, they did not follow up with the youth to facilitate their participation in the program. Further assessment and services were needed to support the youth's health needs.

Prior to the case review being finalized discussions occurred regarding timely file assignments, reorienting staff to service mandates, developing a system to clarify and monitor referrals, and establishing monthly collaborative meetings.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review with the involved staff the screening of child protection reports involving high risk youth with mental health involvement, as well as moving service focus between protection and non-protection focus. Training is provided to support further understanding for staff regarding specific a mental health issue.

The review was completed in June 2021. The above action plan is due for full implementation in December 2021.