BRITISH COLUMBIA

Ref #: 249701
Date: June 2022

Summary: Child and Family Practice Review of the Death of a Youth Known to the Ministry in 2020

Circumstances of the Fatality

The review examined the ministry services provided to a youth who died. The youth and their family were receiving services at the time of the death.

Findings

There was no documentation of an assessment or plan when the youth identified a mental health issue. Based on the circumstances, these were required. When further concerns of the youth's mental health were raised there was no record of an assessment or plan being created.

Prior to the review being finalized, a webinar was provided to targeted staff within the Service Delivery Area regarding a mental health issue.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide mental health training regarding a specific issue to involved staff, and to discuss with team leaders the requirement for having regular clinical supervision to identify youth with a specific mental health issue and review the assessment and planning for them.

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