

SUMMARY: FILE REVIEW

Of the Death of a Youth in the Care of the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted the File Review (FR) to examine the case practice and services provided to the subject youth (the youth).

For the purposes of the FR, Ministry records and BC Coroners Service documents regarding the child were reviewed. The focus of the FR was a specific period of Ministry involvement prior to the death of the youth.

B. TERM OF REFERENCE

1. Were guardianship responsibilities with regard to the planning for the youth's safety and well-being conducted according to policy and legislation in collaboration with Ministry programs?

C. BACKGROUND SUMMARY

There was longstanding involvement with the Ministry due to concerns regarding the parents' capacity to address the youth's high-risk behaviors. The youth was brought into the care of the Ministry because of these issues. The youth participated in services from another Ministry program, and a community support worker for an extended period of time. After these services ended, the youth developed an additional issue that required service. The youth was not Aboriginal.

D. FINDINGS

1. The Ministry's guardianship responsibilities were partially fulfilled. Collaboration occurred with one Ministry program; however, collaboration with another Ministry program was not evident. The youth required service for an additional issue, which was not addressed in a timely manner, due to this lack of collaboration. The youth required a revised plan to address the recommendations associated with the issue; this did not occur. A revised plan would have provided an opportunity for full collaboration of the involved Ministry programs and support services in order to monitor the effectiveness of services and the youth's

progress. The youth's temporary placement did not provide the level of supervision and support required for high risk behaviours.

E. ACTIONS TAKEN TO DATE

1. Discussions occurred at a Leadership Forum in the Service Delivery Area regarding documentation, critical thinking, and using the Integrated Case Management system to assist in tracking the progress of youth.

F. ACTION PLAN

1. Implementation of a pilot project for permanency and transition planning with the Service Delivery Area.
2. The importance of a transition process when a case transfers to a different social worker, and collaboration between child protection, child and youth with special needs, youth justice, and child and youth mental health is discussed at a Leadership Forum with the Service Delivery Area.

This review was completed in November 2016. The above Action Plan is due for full implementation in December 2016.