BRITISH COLUMBIA

Ref #: 233622
Date: June 2018

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) of the FR

For the purposes of the FR, ministry records were reviewed. The focus of the FR was the period of ministry involvement prior to the death of the youth.

B. TERMS OF REFERENCE

1. Did the ministry adequately assess the youth's safety (particularly the risk of suicide), and develop a plan to monitor their well-being?

2. Did the ministry teams collaborate regarding the youth's best interests during their response to the protection reports, along with the subsequent family assessment and planning?

C. BACKGROUND SUMMARY

The ministry had been involved with the family for several years due to concerns of substance misuse, domestic violence, parental capacity, and high risk behaviour by the youth and a sibling. The family engaged with community services during earlier interventions, without long term success, and was not involved in any services at the time the youth died. The youth was Indigenous and in the care of the ministry at the time of death.

D. FINDINGS

1. The ministry did not adequately assess the youth's safety or plan for the youth's well-being. Multiple child protection reports were received that did not result in the required steps of the investigations being completed. Structured Decision Making Tools were not completed and service plans were not created to plan for the youth.

2. The ministry partially collaborated in their response to the protection reports, subsequent family assessment, and planning. Each Service Delivery Area (SDA) primarily focused on the family member in their community with little attention/services being paid to the family unit as a whole. There was no evidence that the youth's mental health was assessed by Child and Youth Mental Health after multiple suicide attempts leading up to the death.

E. ACTIONS TAKEN TO DATE

1. The Executive Director of Service for one of the SDA has had discussions with the involved staff regarding the Practice Directive: Case Transfer & Joint Case Management and the importance of having a written plan of the roles and responsibilities when there is more than one involved office.
2. The Executive Director of Service for one of the SDA is working with the local Health authority on improving the referral process to Child and Youth Mental Health when youth are seen at hospital for self-harm, suicidal ideation, or suicide attempts.
3. The Director of Practice for one of the SDA has engaged in discussion with the legal services branch and the Attorney General regarding 3rd party reports for CYMH services (hospitals, doctors, schools, police etc.) to determine if the *duty to consent* trumps the duty to document the children/youth that are reported to have mental health concerns.
4. As a result of a previous Action Plan, the Director of Practice for one of the SDA is developing *a 'practice aid' to assist in the assessment of behaviours that may indicate suicide risk, as well as prompts for the appropriate actions that should be taken,* and will review with the Local Service Area staff.
5. On November 6, 2017, the Provincial Director of Child Welfare requested the Provincial Practice Branch lead a review of the Practice Directive: Case Transfer & Joint Case Management under the Child, Family and Community Service Act, to examine the effectiveness in promoting a continuity of child welfare services. This review is underway and the associated policy, found in Chapter 1, is targeted to for completion during the summer of 2018.

F. ACTION PLAN

1. The Directors of Practice, for both of the Service Delivery Areas, discuss with the involved staff, including management, the Case Transfers & Joint Case Management practices, and update with the new Chapter 1 policy when it comes into effect (expected summer 2018).
2. The Director of Practice for one of the SDA meet with the involved staff and emphasize the steps in using the Structured Decision Making tools to guide the work of completing a Family Development Response.
3. The Director of Practice for the other SDA meet with the involved staff and emphasize the importance of using the Structured Decision Making tools,

specifically the Family Plan and Strength & Needs Assessment, as a means to guide the work with a family, as well as to document the ministry's decision-making.

The review was completed in May 2018. The above action plan is due for full implementation in September 2018.