BRITISH COLUMBIA

Ref #: 243564
Date: June 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth in the Care of the Director in 2019

Circumstances of the Fatality

The review examined the case files of a youth who died while in the director's care. The director was providing services to the youth and their family at the time of the death in relation to abuse and health concerns.

Findings

While in the care of the director, concerns for the youth's health were addressed through a collaborative Care Team and community support services. Regular Integrated Case Management meetings occurred to discuss planning for the youth's needs. A written Safety Plan and Care Plan for the youth were not completed; these could have informed the supports and services offered to the youth with regard to their health and well-being.

Prior to the case review being finalized, the Service Delivery Area (SDA) leadership participated in several initiatives to enhance collaboration and communication with community partners. A Community Critical Response Steering Committee was developed to address critical incidents and high-risk situations. In addition, discussions occurred with a specific community partner with regard to information sharing, duty to report, roles and responsibilities, and proactive collaboration.

Actions

The involved SDA leadership and Quality Assurance Team developed an action plan for the Director of Operations, with support from the Director of Practice, to review with the involved staff the importance of prioritizing and completing Safety Plans for youth and the timely completion of Care Plans.

The review was completed in May 2020. The above action plan is due for full implementation in October 2020.