BRITISH COLUMBIA

Ref #: 250279
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. The youth, and their family, were receiving services at the time of the death.

Findings

The youth's health and safety needs were not met by the ministry prior to their death. Comprehensive assessments and planning did not occur to address their mental health concerns. When a new child protection report was received, the ministry assessed that there were no child protection concerns and determined no further action was required; however, the youth and their family could have been contacted to offer support services.

Prior to the case review being finalized, a new process was developed in the Service Delivery Area to discuss issues, concerns, and training requirements. A discussion also occurred with the involved leadership team around the importance of completing and documenting assessments and planning.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review the importance of file documentation, the duty to report child protection concerns, and the use of Service Requests to determine the need for support services. Specific training occurred for staff to support them to provide provision of mental health supports.

The review was completed in November 2021. The above action plan was completed in December 2021.