BRITISH COLUMBIA

Ref #: 252470
Date: December 2021

SUMMARY: FILE REVIEW
Of the Death of a Youth in the Care of the Director in 2020

Circumstances of the Fatality

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

Findings

The director developed, implemented, and monitored a care plan to support the youth's transition to the community. Regular transition planning Circles were held, and the youth was supported by their care team to engage with services. Although the youth's family was involved in planning and decision making, the views of the youth's Indigenous community were not known. Joint case management occurred but could have been arranged sooner based on the youth's circumstances. Monitoring the youth's plan more frequently could have improved communication, service delivery, and planning for their specific needs.

Prior to the case review being finalized, guardianship sessions were provided to staff and a process was developed to support collaborative planning and communication between the director and the resource.

Actions

The involved Service Delivery Area (SDA) and the Quality Assurance team developed an action plan to review with the involved staff the practice directive regarding case transfer and joint management and arranged for staff to complete training specific to working with Indigenous families and communities. A discussion with SDA leadership also occurred on planning for youth transitioning to the community.

The review was completed in September 2021. The above action plan was fully implemented in November 2021.