BRITISH COLUMBIA

Ref #: 257651
Date: December 2021

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

Circumstances of the Fatality

The review examined the ministry services provided to an Indigenous child who died. The director was providing guardianship and family support services to the child and their parents at the time of the death.

Findings

In the eight months before the child's death, the ministry thoroughly assessed and created comprehensive plans to address the child's medical and developmental needs. This included the child's extensive care team meeting on a regular basis to plan for them, contributing to their referral for and participation in appointments with medical professionals and therapists. Reassessment of the child's placement with a sibling in a family care home could have supported their need to be connected to their family and culture.

Prior to the case review being finalized, the involved staff completed guardianship orientation training, reviewed their roles and responsibilities. Additionally, the involved staff participated in monthly practice circles to share information and practice strategies in serving Indigenous children and families. Involved leaders had access to similar practice circles and participated in monthly meetings focused on permanency, in which discussions and tracking of placement reassessments took place.

Actions

No further actions were required to address the findings of the review.

The review was completed in November 2021.