BRITISH COLUMBIA

Ref #: 258331
Date: June 2022

Summary: Child and Family Practice Review of the Death of a Youth Known to the Ministry in 2021

Circumstances of the Fatality

The review examined the ministry services provided to a youth who died. The youth and their family received services at the time of the death.

Findings

A required initial assessment was not completed when the youth began receiving mental health services. Over the following year, their risk related to mental health issues was not assessed, and a safety plan was not developed to mitigate any risks. Recommendations for working with the youth were not followed. The youth required an assessment of their needs and a plan developed to address these needs, and consultation with a supervisor was warranted, but these did not happen.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review the documented circumstances in a sample of children and youth who receive mental health services, documentation requirements, recommendations during clinical supervision, and the assessment of risk related to mental health issues.

The review was completed in December 2021. The above action plan was fully implemented in February 2022.