BRITISH
COLUMBIA

Ref #: 271122
Date: December 2023

Summary: Child and Family Practice Review of the Death of a Child in the Care of the Director in 2022

Circumstances of the Fatality

The review examined the services provided to an Indigenous child who died. The child received guardianship services at the time of the death.

Findings

The guardianship needs of the child were met. The caregivers were supported to meet the child's needs; however, the child's needs exceeded the capacity of the caregivers and planning was underway to move the child to a new family care home. Extensive efforts were made to connect the child to their family and culture. When the child experienced issues, their needs were assessed and planned for, and the child was referred to a community program. Coordinated efforts with community professionals occurred to address a specific issue.

Initially the child's mental health needs were thoroughly assessed and planned for. Once the service ended, a different mental health program continued to support the care team and the caregiver. A further mental health service was engaged to provide direct support to the child; however, this did not commence prior to the child's death.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review with team leaders, the requirements for documentation of a specific issue. The Child and Youth Mental Health Policy team and the Quality Assurance team developed an action plan to develop policy guidance to support practitioners.

The review was completed in July 2023. The above action plan was fully implemented in November 2023.