BRITISH COLUMBIA

Ref #: 275962
Date: June 2024

Summary: Comprehensive Review of the Death of a Youth in the Care of the Director in 2022

Circumstances of the Fatality

The review examined the services provided to a youth who died. The youth received guardianship and support services at the time of the death.

Findings

The youth's guardianship needs were partially assessed and planned for during the period of review. Attempts were made to support the youth with activities they enjoyed and to have contact with the youth; however, the youth was not seen as frequently as policy required. A care team was not gathered to identify and support the youth's needs and the youth's relational permanency was not assessed or maintained.

The youth was not met with for support services, though their information was collected and mental health consultation was provided to their caregiver, without their consent.

Prior to the review being finalized, a new branch was formed to support child safety, including tracking visits with children/youth in the care of the director. The involved Service Delivery Area reviewed policies, procedures and practices related to the findings of the review with involved staff and changes were made to the referral process for specific services.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review policy related to the findings of the review with the team leaders and acting team leaders in the local service area. The involved Mental Health Services leadership developed an action plan to provide orientation regarding service provision to children over 12 and under 12 based on their consent to service.

The review was completed in May 2024. The above action plan is due for full implementation in September 2024.