

## **SUMMARY: COMPREHENSIVE REVIEW Of the Death of a Youth in the Care of the Ministry**

### **A. INTRODUCTION**

The Ministry of Children and Family Development (the Ministry) conducted the Comprehensive Review (CR) to examine the case practice and services provided to the subject child (the child) of the CR.

For the purpose of the CR, Ministry electronic and physical records and BC Coroner Service documents were reviewed. Ministry staff members were interviewed. The CR focused on the period of Ministry involvement prior to and following the death of the child.

### **B. TERMS OF REFERENCE**

1. Did the Ministry programs (Child Youth Mental Health (CYMH) & Child Protection) adhere to applicable legislation, policy and service standards in the provision of services to the youth and the family?
2. Did Ministry programs collaborate effectively in providing services to the youth and the family?
3. Did the Ministry utilize the local Memorandum of Understanding with regard to transitions and discharge planning between acute health services and community CYMH services?

### **C. BACKGROUND SUMMARY**

The Ministry had longstanding involvement with the youth and the family due to concerns about the youth's mental health. The youth was resistant to services; however, the family remained engaged. The concerns could not be adequately resolved and the youth was removed from parental care. The youth was in care of the Ministry at the time of death.

## **D. FINDINGS**

1. The Ministry's assessment and plan of treatment did not fully meet the expectations of applicable legislation, policies and practice standards.
2. The Integrated Case Management (ICM) meetings were not documented effectively and did not engage the youth.
3. The Ministry staff working with the youth were not familiar with the Memorandum of Understanding with regard to discharge planning between acute Health services and community CYMH services.

## **E. ACTIONS TAKEN TO DATE**

1. Practice guidelines for working with children and youth at risk for suicide in community mental health settings were issued by the Ministry after this incident.
2. Practice guidelines for working with children and youth who have experienced trauma were also released by the Ministry after this incident.
3. New CYMH policies relating to assessment, planning and treatment for youth at risk of suicide were released by the Ministry after this incident.
4. The Ministry created a local tracking sheet to monitor the completion of care plans for children and youth.

## **F. ACTION PLAN**

1. The Community Service Manager will meet with the CYMH TL to implement a tracking system for CYMH assessment and treatment plans.
2. The Community Service Manager will ensure Team Leaders are having Ministry staff document ICM meetings and encouraging youth engagement.
3. The CYMH Team Leader will review the existing CYMH MOU with relevant Ministry staff.