

SUMMARY: FILE 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 File Review (FR) to examine the case practice and services provided to the subject youth (the youth) of the FR.

For the purpose of the FR, Ministry records, policies, standards, guidelines, and legislation in effect were reviewed. The FR focused on a specific the period of Ministry involvement prior to the death of the youth.

B. TERM(S) OF REFERENCE

1. Was the Ministry's assessment of the safety and well-being of the youth (particularly in relation to suicide) consistent with relevant legislation, policies, practice standards and guidelines?
2. Was an appropriate service plan developed, implemented and monitored to adequately address the safety and well-being of the youth?

C. BACKGROUND SUMMARY

The Ministry had longstanding involvement with the youth and family, due to concerns of parental substance misuse, domestic violence, and neglect. The youth was Aboriginal, and had been in the continuing care of the Ministry for many years at the time of death.

D. FINDINGS

1. The Ministry's assessment of the youth's safety, well-being and risk of suicide did not fully meet the expectations of applicable legislation, policies and practice standards. The actions taken with regard to the youth's suicidality were inadequate to support the youth.
2. The Ministry did not adequately plan for the youth's cultural continuity, transition out of care, substance abuse, or mental health. There was no permanency plan in place, nor any cultural plan to ensure connection with the youth's Aboriginal community.

E. ACTIONS TAKEN TO DATE

1. Cultural Safety training was completed with three local child protection workers and one consultant between April 28, 2014 and May 9, 2015.
2. A Provincial Practice Consultant reviewed the recent Reportable Circumstance Policy, and accompanying PowerPoint presentation, with local staff on December 2, 2015. Another training session occurred with staff on July 7, 2016 which was specifically related to completing Reportable Circumstances on missing youth.

F. ACTION PLAN

1. Local Service Area Ministry staff are trained in transition planning for youth, as well as how to engage service providers and the Aboriginal community in planning.
2. Local Service Area Ministry staff receive education and support on how to address suicidal behaviour; including safety planning and how to engage high-risk youth in services.
3. The appropriate Team Leaders within the Local Service Area implement tracking of Care Plans for youth to ensure timely completion.
4. The remaining Local Service Area child protection workers complete Cultural Safety training.

This review was completed in September 2016. The above Action Plan was due for full implementation in November 2016.