

SUMMARY: FILE REVIEW

Of the Death of a Youth in the Care of the Director in 2019

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died accidentally. The youth was receiving guardianship services at the time of their death.

Findings

The director developed a collaborative plan to address the youth's needs, with a specific focus on cultural, relational, and physical permanence. Further inclusion of the youth's Indigenous community in decision making and a clearer framework for guardianship responsibilities was required. While transferring the youth to guardianship services, there was a period of limited file documentation related to service planning.

Prior to the case review being finalized, new procedures were developed for a file transfer process and the involved staff reviewed policies related to file documentation.

Actions

No further actions were required to address the findings of the review.

The review was completed in March 2021.