

SUMMARY: FILE REVIEW

Of a Critical Injury of a Youth Known to the Ministry

Circumstances of the Critical Injury

The review examined the case files of a youth who was critically injured. The director was providing services to the youth and their family at the time of the critical injury.

Findings

The youth was temporarily in the care of the director and returned home to their parents' care once the safety concerns were addressed and support services were provided. Family members were engaged with services, and collaborative planning occurred between the director and community partners. The director's response to new child protection concerns was inconsistent in that some child protection reports were addressed while others were not. Tools to guide decision making were not utilized, risk assessments and safety plans were not completed, and an integrated service plan was not developed with the involved service providers.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review the following with the involved staff: the procedures for assessing new child protection reports, completing Structured Decision Making Tools, the family service practice cycle, using collaborative practices, the importance of completing mental health risk assessments and safety plans, and following the recommended evidence-based approach to therapy. A team leader forum is being arranged to discuss collaboration and integrated case management practices.

The review was completed in November 2020. The above action plan is due for full implementation in February 2021.