

## **SUMMARY: FILE REVIEW Of the Death of a Youth in the Care of the Director in 2016**

### **A. INTRODUCTION**

The Ministry of Children and Family Development (the ministry) conducted the File Review (FR) to examine case practice regarding the subject youth (the youth).

For the purpose of the FR, ministry records, agency records, and BC Coroners Service documents were reviewed. The FR focused on a specific period of ministry involvement prior to the death of the youth.

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

1. Were guardianship and transition planning responsibilities, including an offer of services under a specific program, consistent with the expectations outlined in legislation, policy and practice standards?
2. Were guardianship services provided in collaboration with other ministry programs?

### **C. BACKGROUND SUMMARY**

The family had an extensive history of involvement with the ministry due to high risk and criminal issues. After an extended period the family began to receive services from a Delegated Aboriginal Agency (DAA) to address identified issues. The youth and their siblings were brought into the care of the director, and a continuing custody order was granted. The youth resided with their siblings in a foster home for a period of time; however, the youth moved to a different home due to high-risk issues. The youth had numerous placement changes throughout their time in the care of the director. An assessment indicated the youth was eligible to receive specific support for high-risk issues. The youth did not have an identified place to live for a period of time. The youth was Indigenous.

## D. FINDINGS

1. For the most part, the guardianship and transition planning responsibilities were consistent with legislation, policy, and practice standards. While the youth was at a specialized placement, the placement staff addressed these responsibilities. The DAA exceeded the expectations of contact with the youth, and developed plans to address identified issues. This level of support did not continue at subsequent placements, resulting in the youth's safety and well-being not being fully addressed. The DAA successfully connected the youth with their culture and family.

The ministry closed the youth's placement and subsequent placements did not address the youth's high-risk issues. This left the youth in a high-risk situation without access to supports required by legislation. There was no policy, guideline, or legislation on how to develop a specialized agreement with a youth with a specific need, and who engaged in high-risk activities. The support system developed by the social worker was innovative as it involved the collaboration of supports and family to help the youth.

The youth was resistant to engage in services, and the DAA did not have access to specialized consultation regarding high risk youth behaviours. The DAA was unaware of the option of referring the youth to a specialized program, which could have provided consultation and support for those working with the youth; to address concerns for the youth's safety and well-being, and alternative placement options.

There was no indication the DAA developed safety plans with the youth to address the multiple high-risk issues the youth was exposed to. During the last months the youth was in the care of the director, they refused any placements offered and did not have a place to live. The DAA social worker developed a strong relationship with the youth and their immediate family to support continued innovative ways to establish a relationship with the youth, and address their safety and well-being through connections with family and other community supports.

After the youth transitioned out of the director's care, thorough guidance was provided on how to make further attempts to engage the youth and offer the necessary supports to address the youth's high-risk complex needs. There was no indication that the direction was followed.

2. Guardianship services were provided in collaboration with ministry programs. The DAA social worker demonstrated collaboration by having regular contact with ministry workers to develop plans that addressed the youth's high-risk behaviours. Policy did not require a referral or collaboration with a specific ministry program. The DAA appropriately referred the youth to a community program, yet the youth did not engage in services with that program.

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

1. Policy: Investigations of Contracted Agencies came into effect.
2. Children and Youth in Care Policies, which included policy for using Independent Living Agreements, came into effect.
3. Agreement with Young Adults Policy was updated to: increase the age limit and duration of services; and expand the eligibility criteria to include connection with life skills programs.
4. High-risk youth with concurrent issues are routinely identified, and staff who are qualified to work with these youth manage their cases.
5. The DAA was informed of a specialized policy, and the relevancy of the policy to this case was discussed.
6. The DAA discussed with the ministry, and an Indigenous service partner, the need to work collaboratively when high-risk youth are identified as being transient between geographical areas.

## **F. ACTION PLAN**

1. The actions taken to date addressed the findings of the report; no further actions required.

**The review was completed in November 2018.**