

SUMMARY: COMPREHENSIVE REVIEW Of the Death of a Youth Known to the Director in 2017

Circumstances of the Fatality

The review examined the case files for an Indigenous youth who died accidentally. A Delegated Aboriginal Agency (DAA) attempted to assess reported concerns for the youth's safety and well-being in the months prior to the youth's death.

Findings

Approximately six months before the youth's death, the Ministry of Children and Family Development (the Ministry) received a report about the youth's high-risk behaviors, and concerns for their safety and well-being in the home. The Ministry transferred the report to a DAA the following day. The DAA developed a plan to assess the youth's safety and well-being, and made repeated attempts to contact the youth and their family by phone, home visits, and relaying messages through a community support worker.

The DAA was unable to reach the youth or their family directly, partly due to an incorrect address provided by a community professional. Continued attempts did not occur because there was limited staff available, and because the DAA received information about factors mitigating the risks to the youth: an adult family member who was protective of the youth was living in the home; the youth had requested assistance when an issue at the home came up; and the community support worker did not have concerns about the youth's safety. The team leader directed the social worker assigned to the case to send a formal request for information to a community agency to help locate the family; this did not occur.

Prior to the case review being finalized, additional staff were assigned to the team responsible for the youth's case; the team reviewed and adapted its practice in tracking and responding to reports involving families they are not able to contact; and a meeting took place between the DAA and a community agency to improve their communication.

Actions

The Ministry's Quality Assurance Team facilitated a discussion with the involved DAA leadership. Previously completed actions by the DAA addressed the findings of this review; therefore, an action plan was not required.

The review was completed in February 2019.