

Ref #: 238326

Date: December 2019

SUMMARY: COMPREHENSIVE REVIEW Of the Death of a Youth in the Care of the Director in 2018

<u>Circumstances of the Fatality</u>

The review included an examination of case files and discussions with the involved staff for a youth who died while in the care of the director. The director was providing services to the child and their family at the time of the death in relation to concerns of neglect by the parents.

Findings

The director received a report the youth's parents were unwilling to provide care for them; however, no planning occurred, and the director did not provide supports to the family to address the concerns until another, more urgent report was received two months later. At that time, the director collaborated with the family and planned for the youth to come into the director's care. No additional planning or supports were provided to the parents to work towards reuniting the youth with their family. The director met with the youth and attempted several referrals which did not materialize in supports for the youth. The youth remained in the same placement for the duration of their time in care. On multiple occasions, when the youth did not return to their residence the care provider attempted to locate them in the community; however, the director did not complete any of the required Reportable Circumstance reports.

Prior to the case review being finalized, the involved staff reviewed practice guidelines related to issues identified through the case review, such as Responding to and Supporting Youth at Risk and/or Parent(s) Known to be Using Illicit Opioids, and the Protocol Agreement Regarding Missing Children and Youth. They also completed Problematic Substance Misuse Training.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide a forum on the best practices, guidelines, and policies for working with high-risk youth. Additionally, the involved staff were to review the policy on Case Transfer and Joint Case Management under the *Child Family and Community Services Act* and the Key Player guidelines.

The review was completed in September 2019. The above action plan was fully implemented in December 2019.