

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

Circumstances of the Fatality

The review examined the case files of a youth in care who died. The Director was providing services to the youth and their family at the time of the death in relation to the youth's health concerns, developmental challenges, permanency planning, and transition from care into the community.

Findings

While in care, the youth was involved with multiple services to address their particular needs and maintained a close relationship with their family. After there were significant improvements in the youth's health and well-being, a permanency plan was developed to return the youth to the care of their parent. Three months prior to the intended return home, there was a brief hospitalization due to health concerns. Following discharge, the care team developed a safety plan and continued to provide support to the youth.

The youth's health and permanency needs were addressed through a care plan; however, the plan was not comprehensive and did not use an integrated approach characterized by collaboration with involved services and programs. An integrated plan would have supported the youth's transition into the community; strengthened relationships between the youth and their family; clarified how to address concerns for the youth; and informed decision making.

Actions

The Ministry's Quality Assurance Team facilitated a discussion with the involved Service Delivery Area leadership, resulting in an action plan for the Director of Practice to meet with involved staff and discuss the importance of collaborative practices.

**The review was completed in March 2019. The above action plan was due for full implementation in April 2019.**