Ref #: 241402
Date: June 2020

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 an Indigenous youth who died from medical complications. The director was providing services to the youth and their family at the time of the death in relation the youth's complex medical needs.

Findings

The youth came into the care of the director through a Special Needs Agreement. The youth had a Care Plan that identified their complex needs; there were also medical assessments and medical care plans provided to the director, and the care team, to assist with planning for the youth's specific health needs. It was evident, through the extensive case notes and file documentation, the care team was aware of the goals outlined in the plan and the youth's medical issues. The team communicated regularly on how to support the youth. The youth's Care Plan did not consider information about their Indigenous heritage. Engaging the Indigenous community, and ensuring they were part of the youth's circle was important in addressing the youth's inherent right to culture, community and connection, and would have aligned with the Ministry of Children and Family Development's Aboriginal Policy and Practice Framework (APPF).

Actions

No actions were required to address the findings of the review.

The review was completed in November 2019.