Ref #: 238391
Date: June 2019

SUMMARY: FILE REVIEW
Of the Death of a Youth not in the Care of the Director in 2018

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died accidentally. The Director was providing services to the youth in relation to their transition from care into the community, and to adult services.

Findings

Significant effort was made to provide support and services to the youth as they transitioned from care. After the youth turned 19, the Director remained involved as a support to the youth, endeavoring to address well-being issues and their struggle to maintain appropriate housing. Senior level management in the Service Delivery Area (SDA) provided support and consultation to staff who were planning for the youth.

Although several creative approaches were used to engage the youth in planning, this did not include a discussion with the youth about their legislative rights according to the *Child Family and Community Service Act; Section 70.* Increased collaboration with the youth's First Nation community would have facilitated an opportunity for the youth to obtain more culturally appropriate services to aid in their transition from care. The youth's transition from care into the community would have benefitted from trained, trauma informed caregiver support.

Actions

The Ministry's Quality Assurance Team facilitated a discussion with the involved SDA leadership, resulting in an action plan to form a focus group in the Local Service Area to provide staff with suggestions on creative ways of engaging youth with complex needs in conversation about their legislative rights.

The review was completed in April 2019. The above action plan is due for full implementation in June 2019.