SUMMARY: COMPREHENSIVE REVIEW
Of the Death of a Youth in the Care of a Delegated Aboriginal Agency

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted a Comprehensive Review (CR) to examine the case practice and services provided to the subject youth (the youth).

For the purpose of the CR, Ministry and Delegated Aboriginal Agency (DAA) records were reviewed. Service documents and the BC Coroner reports were reviewed. DAA staff, ministry staff, a care provider and community professionals were interviewed. The CR focused on the nine-month period preceding the death of the youth.

B. TERMS OF REFERENCE

1. Was the transition planning associated with the youth’s move from one placement to another placement consistent with legislation, policy and standards in accordance with the assessed needs and direction?

C. BACKGROUND SUMMARY

This youth, who was Aboriginal, had been in care from a very young age. The concerns that brought the youth into care could not be adequately resolved and there was no extended family that could provide the care required. The youth remained in care and was not referred for adoption. There were twenty placements by the age of 18.

D. FINDINGS

1. The youth had a severe attachment disorder that had never been effectively addressed and was fearful of leaving care and losing social and financial supports. The transition planning for the youth did not adequately address those fears and needs.

2. The DAA had provided CYMH, addiction programs, work experiences and personal counselling.

3. The planning for transitioning the youth out of long term placement was not adequate for the assessed needs and not in accordance with the policies and standards. The plan lacked collaboration between the DAA staff, the community
service providers who had long term relationships with the youth and collaboration with the Aboriginal Services Branch.

E. ACTIONS TAKEN TO DATE


F. ACTION PLAN

1. The DAA provides a practice directive to all staff on responding to children and youth who are at risk or threaten suicide, which includes the implementation of a local protocol for responding to high risk children and youth, including those at risk of suicide. The protocol clarifies requirements, procedures, roles and responsibilities of staff and service providers.

2. The DAA finishes training all delegated staff in suicide intervention through the Crisis and Trauma Response Institute.

3. The DAA forms a youth transition team to provide practice support and consultation to social workers and service providers working with youth, including high risk youth transitioning out of care. The team is comprised of a new Youth Transition Coordinator, new Practice Manager, and Aboriginal Mentors.

4. DAA Managers hold monthly meetings to consult, plan and coordinate services to high risk children and youth served by the agency.

5. The DAA sends a communique to all staff (in collaboration with Aboriginal Services Branch) clarifying the process for communicating urgent child welfare matters requiring the attention of the agency and the Provincial Director of Child Welfare.

6. The DAA attends the MCFD Expansion Training for Agreements with Young Adults (August and September 2016).

7. MCFD reviews policies, services and budget for transitioning youth out of care, including Agreements with Young Adults.

8. MCFD implements a system for alerting designated directors to children and youth in care who are at risk of and experiencing frequent changes in caregivers.

This case review was completed in June 2016. The above Action Plan is due for full implementation by March 31, 2017.