BRITISH COLUMBIA

Ref #: 229653
Date: June 2017

SUMMARY: FILE REVIEW
Of the Critical Injury of a Youth in the Care of the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the ministry) conducted the File Review (FR) to examine the case practice and services provided to the subject youth (the youth).

For the purposes of the FR, ministry records, legislation, policy, and standards were reviewed. The focus of the FR was a specific period of ministry involvement prior to the critical injury of the youth.

B. TERMS OF REFERENCE

1. Was the ministry's assessment of risk to the youth consistent with relevant legislation, policy and service standards?

2. Was an appropriate plan developed, implemented, and monitored to address the safety needs of the youth?

C. BACKGROUND SUMMARY

The ministry had longstanding involvement with the youth's family due to high-risk and criminal behaviours of the parents. The youth was Aboriginal. The youth had a high-risk issue, which informed the decision to bring the youth in to ministry care. While in care, the youth received assessments that recommended the youth remain in care until the high-risk and criminal behaviours of the parents and the high-risk issues of the youth could be addressed. After a specific event, the youth was returned to a parent. The youth remained with the parent for a brief period of time, and then moved to the home of extended family members.

D. FINDINGS

1. The ministry's assessment of risk to the youth was inconsistent with relevant policy and service standards. The ministry incorrectly assessed the youth for a specific ministry service after the youth engaged in a high-risk activity while residing with relatives. The required assessment of the youth's safety could have

determined that the youth did not have the appropriate support to address the identified risks.

The ministry denied the youth's request to be placed in ministry care. This option would have met the youth's needs given the circumstances. As an alternative, the ministry assessed the youth for a specific ministry service; this assessment occurred over an extended period of time. The youth did not engage with services on a consistent basis, and without a stable placement the youth alternated between a shelter and the siblings' homes. This was not adequate to address the youth's needs as the youth did not have stable housing and the youth's specific needs were not met. Assessment and planning to address the safety and well-being of the youth did not occur according to policy.

Following the issue which prompted this review, the ministry did not initiate the required response to address the youth's high risk issues.

2. An appropriate plan was not developed, implemented and monitored to address the youth's safety needs. In the absence of ministry planning, a parent's band relocated the youth to another community to receive support for a high-risk issue. Once in the new community the ministry attempted to develop plans in collaboration with the youth, the Aboriginal community, and service providers.

   The youth was unable to follow through with expectations due to the youth's special needs, and high-risk issues. The ministry requested the Aboriginal community find a stable placement for the youth with extended family; this did not occur. There was no indication that the ministry developed a plan to facilitate other formal connections with the youth's Aboriginal community or locate a stable placement to address the youth's safety and well-being. Without an adequate plan, the youth remained without a place to live, and unaddressed high-risk issues.

E. ACTIONS TAKEN TO DATE

Not applicable.

F. ACTION PLAN

1. The Executive Director of Service sends a communication to the Service Delivery Area staff to clarify that it is an option to take youth under the age of 19 into care in certain circumstances, particularly when youth have complex needs and/or high-risk behaviours.
2. The Executive Director of Service communicates to the Service Delivery Area staff the requirement to document consultations with the Aboriginal community.

3. The Director of Practice reviews with the team leaders of the Service Delivery Area the requirement to review current concerns and previous ministry involvement when assessing reports, and when making a decision to use a youth services response or a protection response.
4. The Executive Director of Service ensures that the staff within the Service Delivery Area review the applicable practice directive.
5. The Executive Director of Service meets with the responsible Directors of Operations to develop a plan to address the outstanding concerns for the youth's safety and well-being.

The review was completed in March, 2017. The above action plan is due for full implementation in October 31, 2017.