

## **SUMMARY: FILE REVIEW Of the Death of a Youth Known to the Ministry**

### **A. INTRODUCTION**

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

For the purpose of the FR, ministry records were reviewed. The FR focused on a specific period of ministry involvement prior to the critical injury of the youth.

### **B. TERMS OF REFERENCE**

1. Was the assessment of the youth's safety and well-being consistent with relevant policy and legislation?
2. Was an appropriate service plan developed, implemented and monitored to adequately address the safety and well-being of the youth?

### **C. BACKGROUND SUMMARY**

The ministry had longstanding involvement with the parent due to high risk issues. A criminal issue affected the youth and the youth refused to reside in the home. The youth was involved in high risk issues and came into ministry care on a short term basis. The parent actively engaged in service but the youth was not able or willing to return home, continuing to engage in high risk issues. The youth was not Aboriginal.

### **D. FINDINGS**

1. The ministry's response to the concerns related to the youth's safety and well-being was not adequate according to policy and legislation. An inaccurate assessment resulted in voluntary planning that did not alleviate the youth's high risk issues. Had adequate assessments been completed according to guidelines, the required plan could have been thoroughly informed. The youth continued to engage in high risk issues that could have been alleviated with ongoing protective services.

2. A service plan was developed and implemented to address the youth's high risk issues; however, the plan was not developed in collaboration with the youth and was not informed by thorough and accurate assessments. The youth remained in a high-risk situation as the ministry did not develop a plan in conjunction with the youth, or implement a plan to address the identified risk through protective services.

#### **E. ACTIONS TAKEN TO DATE**

1. The practice guidelines regarding a specific issue was implemented.
2. A specific policy was revised to address a specific issue.

#### **F. ACTION PLAN**

1. The Executive Director of Service and the Director of Operations meet with the staff in the involved Local Service Area to review learning from the case review and guide practice for staff working with high risk youth.
2. Best Practices are developed in collaboration with the Deputy Director of Child Welfare to guide future practice with high risk youth. These Best Practices could be used provincially and will be made available for other Service Delivery Areas to utilize.

**The review was completed in December 2017. The above Action Plan is due for full implementation on April 30, 2018.**