Ref #: 244865
Date: June 2020

# SUMMARY: FILE REVIEW
# Of the Death of a Youth Known to the Director in 2019

## Circumstances of the Fatality

The review examined the case files of a Métis youth who died while the director was providing services to the youth and their family in relation to neglect.

## Findings

The director received two reports about neglect concerns for the youth. These concerns were not sufficiently assessed; the director did not meet with the youth to gather their perspective, collaterals with others who held the necessary knowledge of the youth's situation were not contacted, tools to guide decision making were not utilized, and steps to ensure the youth's immediate safety were not taken. In addition, no plan was developed to address the concerns and the youth's Métis identity was not considered.

Prior to the review being finalized, the involved leadership conducted a review of all protection related cases, identified areas in need of further action, and arranged practice support for social workers in key areas. A plan was also implemented to engage with staff about their successes, challenges, and strengthening their work in a way that is informed by policy, guidelines and best practices.

## Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for the involved staff to be refreshed on the Aboriginal Policy and Practice Framework (APPF), discuss strategies to operationalize the APPF in their work; and, be reoriented on the Child Protection Response Policies, including a discussion about barriers to services and how these policies contribute to improved outcomes for children, youth and families.

**The review was completed in May 2020. The above action plan is due for full implementation in July 2020.**