

## **SUMMARY: FILE REVIEW**

### **Of a Critical Injury of a Youth Known to the Director**

#### Circumstances of the Critical Injury

The review examined the case files of an Indigenous youth who was critically injured. The director was providing services to the youth and their family at the time of the critical injury.

#### Findings

In the months preceding the critical injury, the youth's immediate safety was thoroughly addressed; however, assessments and planning related to the youth's likelihood of future maltreatment did not occur, and services to mitigate the concerns were not implemented. The director did not involve the youth's Indigenous community in planning.

Prior to the case review being finalized, the involved staff reviewed out of care options.

#### Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide the involved teams with training related to completing a protection response, Structured Decision Making Tools and safety planning. Additionally, training was provided to the involved management regarding the involvement of a Delegated Aboriginal Agency (DAA), Nation, and Indigenous community in the assessment of reports when applicable.

**The review was completed in November 2020. The above action plan was fully implemented in November 2020.**