

SUMMARY: FILE REVIEW

Of the Death of a Youth in the Care of the Director in 2019

Circumstances of the Fatality

The review examined the case files of a youth who died while in the care of the director. The youth and their family were receiving services at the time of their death.

Findings

The ministry received multiple requests to provide services to the youth from community partners, the youth's care team and parent. When addressing concerns raised about the youth's safety, the ministry did not complete elements of the Family Development Response, resulting in some crucial details about the youth's safety being missed. The youth was brought into the director's care after four months of service; they were provided a safe placement, support services focused on their high-risk behaviors and other specific needs.

The ministry's provision of a specific service for the youth ended when the youth moved communities and the receiving community would not accept a transfer of services. The ministry staff from the initial community remained involved with the youth's care team to assist with case management responsibilities.

Prior to the review being finalized, the involved staff reviewed policies related to issues identified in the review.

Actions

Leadership from the Policy branch and the Quality Assurance team developed an action plan to retire the current practice directive and create two policies, one for file transfer and one for joint case management, and develop a new policy to support a continuity of care when children, youth or families move to different communities.

The review was completed in February 2021. The above action plan is due for full implementation in September 2021.