BRITISH COLUMBIA

Ref #: 299747
Date: October 2014

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

A. INTRODUCTION

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

For the purpose of the FR a detailed examination of the Ministry files occurred. The FR focused on a period of time prior to the youth's death.

B. TERMS OF REFERENCE

The FR was initiated prior to the Case Review Policy implementation and did not include Terms of Reference.

C. BACKGROUND SUMMARY

The Ministry had longstanding involvement with the youth's family. As a child, the youth was removed due to concerns about the parent's high risk behaviours and came into the continuing custody of the Ministry. The Ministry was involved until the file was transferred to a Delegated Aboriginal Agency (DAA).

The youth resided in a DAA approved foster home with an Aboriginal caregiver for a lengthy period, up until the death.

Prior to the youth's death, key community professionals and Ministry Programs were involved to address concerns related to the youth's needs.

D. FINDINGS

1. There was limited contact and planning for the youth required by the Aboriginal Operational and Practice Standards and Indicators (AOPSI).

2. The DAA did not collaborate with the youth and the foster family towards developing a permanency plan.

3. The DAA, Ministry program and the foster parents did not engage in collaboration or integrated care management to better support the needs of the youth.

4. Information which led to a referral to a specific Ministry Program may not have been adequately or fully been disclosed. The Ministry Program's policy was not met regarding assessment of risk, consultation, planning and documentation.

The youth's safety was impacted by the presence of risk factors that were not fully recognized and addressed during Ministry and DAA involvement. There was no evidence of integrated practice and collaboration that may have resulted in a more sensitive and comprehensive awareness of the youth's functioning and the development of an integrated care plan that acknowledged the risk factors and needs of the youth.

E. ACTIONS TAKEN TO DATE

1. The Ministry completed *Practice Guidelines* specifically related to the risk factors associated with the youth's death. The guidelines were written to strengthen and support existing professional resources for assessing and responding to high risk behaviours among children and youth, with a specific focus on community-based prevention and treatment.

2. The Service Delivery Area's (SDA) Aboriginal youth services implemented an action plan to address priority areas related to factors associated with the death of the youth.

3. The DAA participated in an initiative that promotes permanency planning for children and included provision of learning, support and mentoring for staff.

4. The SDA is implementing an initiative (prior to full provincial implementation) by establishing criteria to identify children and youth with complex needs and developing complex care resources. A provincial unit has been established for eligible children and youth. Children and youth in care are the initial focus.

F. ACTION PLAN

1. The SDA provides specific online and two-day in-person training related to the risk factors identified in the FR to Ministry Program staff who have not yet completed the training. Two training sessions will be offered.