

## **SUMMARY: FILE REVIEW**

### **Of the Death of a Youth in the Care of the Director in 2020**

#### Circumstances of the Fatality

The review examined the case files for a youth who died. The director was providing guardianship services to the youth and their family.

#### Findings

Initially, the assessment and planning addressed the safety and well-being of the youth. As the youth's needs shifted, planning in the community addressed their needs; however, plans were not modified to address the youth's safety within their residence.

Prior to the case review being finalized, the Director of Operations discussed with the resource team leaders that whenever there is a safety plan in place for a child/youth in a resource, the details of the safety plan are clarified.

#### Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to discuss how to record consultations with the team leader in a consistent manner, a check list is to be created for the involved team for high risk youth; and the Director of Operations determines what steps the resource has taken to address a safety concerns for youth.

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