

## **Summary: Child and Family Practice Review of the Death of a Youth Known to the Ministry in 2021**

### Circumstances of the Fatality

The review examined the ministry services provided to a youth who died. The youth and their family received services at the time of the death.

### Findings

The ministry partially fulfilled their responsibilities for the safety and well-being of the youth. Care and support were evident in the relationship between the service provider and the youth. The youth did not receive a fulsome mental health assessment or an assessment of a specific issue for the purpose of treatment and safety planning. There was no record of clinical supervision, and a disclosure did not result in the information being provided as required.

Prior to the review being finalized, a specific mental health assessment was implemented across the province.

### Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review assessment and planning, the duty to report, consent for disclosure, supervision, and documentation.

**The review was completed in July 2022. The above action plan was fully implemented in November 2022.**