

SUMMARY: Child and Family Practice Review of the Death of a Child Known to the Director in 2021

Circumstances of the Fatality

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

Findings

Collaboration between service providers was consistent. The ministry was responsive to the child's needs; however, there was a delay in accessing some of the services due to the child not meeting the criteria for certain programs. Reportable Circumstances Reports were required, yet not completed prior to the child's death. Risk to the child increased before services became available.

Prior to the review being finalized the involved Local Service Area initiated a service redesign to create a team that supports children and youth with high-risk behaviours.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for involved staff to review Reportable Circumstances Policy and the Practice Directive on Clinical Consultation and Support in Complex High Risk Child Protection Cases.

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