

Summary: Child and Family Practice Review of the Death of a Youth in the Care of the Director in 2022

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died. The youth received guardianship and support services at the time of the death.

Findings

The youth's guardianship needs were thoroughly assessed and planned for throughout the period under review. The youth's placement and care team responded to emerging issues regarding the youth's immediate safety and well-being. Action was not taken related to a specific mental health and safety concern.

Prior to the review being finalized, the involved staff reviewed policies and practice directives related to issues identified through the review, and expectations of the specialized program were clarified.

Actions

The policy team and the Quality Assurance team developed an action plan to complete a jurisdictional scan and literature review regarding a specific mental health program and to develop draft policy guidance to support the program.

The review was completed in October 2022. The above action plan is due for full implementation in March 2023.