

## **SUMMARY: Child and Family Practice Review of the Death of a Youth Known to the Director in 2020**

### 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

Child protection reports were not assessed or responded to with a protection response and the youth's immediate safety was not fully assessed. A thorough mental health assessment and plan were not completed. Additionally, there was no record that a specific health issue was monitored regularly and there was no record of clinical supervision.

Prior to the review being finalized, the involved staff reviewed the importance of documentation and the requirement of regular clinical supervision. Training was also provided regarding the requirement to complete child protection responses.

### Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to: complete training on a specific mental health issue; review the need for a comprehensive assessment; discuss how to assess a caregiver's capacity to care for a youth with a specific mental health issue; discuss how to plan for with youth and caregivers regarding a specific mental health issue; and explore how to link caregivers to an outside agency to provide support regarding a specific mental health issue.

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