

SUMMARY: FILE REVIEW

Of the Death of a Youth Known to the Ministry in 2019

Circumstances of the Fatality

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

Findings

Ministry staff and community support programs worked collaboratively to provide the youth and their family with services to meet their needs. The youth and their family were engaged with services and regularly supported by a team of professionals. Concerns for the youth's safety and well-being were properly assessed and addressed when a child protection concern was received. However, the ministry did not submit reports as required, update a plan when needed or inform the youth's family of a mental health issue.

Prior to the case review being finalized, the involved staff received training on completing Reportable Circumstance reports as required by policy, and a process was developed for an annual review of this requirement. A new system was also initiated for ministry staff to regularly review mental health related information.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide involved staff with training related to a specific mental health issue.

The review was completed in August 2021. The above action plan was fully implemented in September 2021.