

## **Summary: Child and Family Practice Comprehensive Review of the Death of a Youth Known to the Director in 2019**

### Circumstances of the Fatality

The review examined the services provided to an Indigenous youth who died. The youth received services in the 12 months prior to their death.

### Findings

The youth had an extensive care team with support in place and was engaged in services to meet their specific needs. There were delays with assessments and challenges with communication and documentation that impacted planning for the youth.

Prior to the review being finalised, training related to new legislation and policy was delivered. Training related to issues identified through the review also occurred. Temporary youth support measures were made available indefinitely.

### Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review documentation requirements.

**The review was completed in April 2023. The above action plan was fully implemented in June 2023.**