

## Summary: Child and Family Practice Review of the Death of a Youth Known to the Director in 2021

### 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

Planning was youth centred and supported connection to the youth's community and culture. Required assessments and notifications did not occur, and planning was not clearly documented. Long-term planning to meet the youth's specific needs was not completed.

Prior to the review being finalised, documentation requirements were reviewed with all staff.

### Actions

The involved Indigenous Child and Family Services Agency leadership and the Quality Assurance team developed an action plan to review specific assessment and notification requirements. Planning related to a specific concern and further review of documentation will also occur.

**The review was completed in May 2023. The above action plan is due for full implementation in July 2023.**