

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 a youth who died. The youth received services in the 12 months prior to their death.

Findings

The youth was supported by a large care team, which made ongoing efforts to address the youth's needs and promote their well-being.

Detailed planning for the youth was absent, and there was role confusion amongst specific team members that may have impacted aspects of planning. The required reports were not submitted.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review a new policy to clarify roles and responsibilities, as well as review policy related to required reporting. A strategy to ensure comprehensive planning is in place for youth with complex needs will also be developed.

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