

Summary: Child and Family Practice Review of the Death of a Child in the Care of the Director in 2021

Circumstances of the Fatality

The review examined the services provided to an Indigenous child who died. The child and their family received services at the time of the death.

Findings

Assessment and planning occurred to address the child's needs while in the care of the director. When the child returned to their parent's care, reports were received about their safety, and an intervention was required; the specific issue was not discussed with the parent. The child subsequently experienced a critical injury and returned to the care of the director; they later died due to their injury.

Prior to the review being finalised new staff were provided with additional training regarding assessments and documentation. All staff completed training about a specific issue, and a consultation document was developed to capture the assessment of a child's vulnerability while in their parent's care.

Actions

The involved Indigenous Child and Family Services Agency leadership and the Quality Assurance team developed an action plan to review the need to discuss specific issues with parents, as well as review documentation requirements and consultation points.

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