Ref #: 267604
Date: December 2023

Summary: Child and Family Practice Review of the Death of a Child Known to 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

The ministry assessed and addressed an initial report of concerns in a timely manner. The family was seen frequently and a referral for services was made. Safety planning occurred with each family member. Additional safety concerns related to the child's well-being were not discussed with the guardian until five weeks after they were received. A required document regarding the concern was not completed. There was initial contact with an Indigenous community; a second community was not contacted. Ongoing contact with the initial community did not occur.

Prior to the review being finalized, the involved staff received training for specific reports.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review with team leaders the need to involve Indigenous communities in the ongoing planning and delivery of services to children and families, as well as considering additional follow up with vulnerable children, youth and families.

The review was completed in September 2023. The above action plan was fully implemented in November 2023.