

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 and their family received services at the time of the death.

Findings

The initial report was responded to in a timely manner, and multiple efforts were made to engage the family in an assessment.

A comprehensive assessment of reported concerns, including collateral contact checks, assessment of specific issues, and consultation to increase response did not occur. Required assessments were not completed in the prescribed timeframes.

Prior to the review being finalised, guidelines related to specific issues were reviewed.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review consultation points and assessment timelines.

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