

Summary: Child and Family Practice Review of the Death of a Child in the Care of the Director in 2022

Circumstances of the Fatality

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

Findings

There was frequent contact with the child. The child participated in planning, which was regularly reassessed to verify it met their needs and was documented as required.

Efforts were made to address a specific issue that was impacting the child's safety. Multiple placement options were presented to the child. The child was offered services to address an identified need.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review with team leaders, the consultation and assessment options to address a specific need.

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