

Summary: Child and Family Practice Review of the Death of a Youth Known to the Director in 2022

Circumstances of the Fatality

The review examined the services provided to an Indigenous youth who died. The youth received services in the 12 months prior to the death.

Findings

The youth's health needs were met. The youth was an active participant in their planning and service support. A specific concern was addressed frequently with the youth.

The ministry did not complete specific reports. Collaborative communication regarding planning for the youth and their family was not documented.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review with local service area team leaders the requirement for staff to complete specific reports, as well as the importance of documenting communication and collaboration with participants involved in the care team.

The review was completed in November 2023. The above action plan is due for full implementation in February 2024.