

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

Findings

The director had frequent contact with the youth and collaborated regularly with their care team to support the youth's engagement in services to meet their specific needs. The director did not engage the youth's Indigenous community or support their legal guardians to participate in planning.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review the policies related to the findings of the review with the Service Delivery Area team leaders, Directors of Operations, and involved staff.

The review was completed in April 2024. The above action plan was completed in May 2024.