Child and Youth Death Review and Analysis Pilot

Local Death Review Table

Report and Recommendations

OCC File #: 2016-500

This document was produced by the Office of the Chief Coroner (OCC) pursuant to the *Coroners Act* for the purpose of making recommendations to prevent further deaths of children and youth. This document does not make any findings of legal responsibility and is not intended to be used to make such findings. Moreover, this document does not necessarily reflect all the facts and circumstances surrounding the death; therefore, the findings expressed in this document is limited to the information provided and considered for the purposes of this review.

Due to restrictions on information about young persons under the *Youth Criminal Justice Act* (YCJA), Local Death Review Tables (LDRT) do not consider any information about whether or how young persons have been dealt with under that Act. This limitation may result in gaps in both the review and the subsequent findings. Recommendations or other information relating to the youth justice sector may be included regardless of whether an individual was dealt with under the YCJA.

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Introduction*

The Local Death Review Table (LDRT) report begins with a short summary of the strengths of the young person. While it is impossible to paint a picture of all aspects of the youth, it is important to share some sense of their strengths and uniqueness, so they are honored for who they were in their life, before we examine the events and circumstances surrounding their death.

This was a youth who was proud of his culture and his community. As he aged he showed increasing desire to explore his Indigenous identity, culture and family. He had many strengths such as his sophisticated sense of humour, which could bring people together and ignite joy.

He was a kind and caring young person and showed this side of himself in his interactions with his community, peers and family. He was always willing to lend a hand or a supportive, listening ear. He had a strong family connection with his mother and siblings.

He was a quiet individual, but in that quiet personality he was a deep thinker and feeler. This was a youth that grew up in the midst of trauma resulting from a legacy of systemic oppression and racism experienced by Indigenous people and communities. Due to these deeper systemic issues he often had to find his own ways of coping with his mental health and other challenges.

He showed courage as he came forward to find help for his individual challenge and traumas. He worked on these challenges with mental health providers and had goals for himself to learn about his culture, to find ways to support his mental wellness, and to a desire to deal with past trauma. He showed resiliency, courage, and vulnerability in attending counselling and therapy sessions which he did for many years. Even though he had some challenges in adapting to the school setting he persevered and committed to his co-op placement where he excelled in this environment.

This was a young man who embraced his identity and special needs. He was a voice for other youth like him and shared his story in a provincial project with the hopes of inspiring other young people. He wanted youth like him to understand that they too had unique abilities and could offer the world hope through their unique gifts, and just because his disability meant he sometimes needed supports he had the right to be heard and understood for who he was at his core. His unique, kind presence will continue to be deeply missed by all those who interacted with him.

**This introduction was created by the Child and Youth Death Review and Analysis (CYDRA) team at the Office of the Chief Coroner (OCC) and is intended to summarize information about the life of the deceased young person gathered by the team during the Local Death Review Table (LDRT) process. Sources for this information may include case file records, family members, service providers and/or community members.*

Information Sources Used for This Review and Report:

- Child Welfare records
- Children's Mental Health records
- Coroner's Investigation Statement
- Hospital Medical records
- Ontario Student Record
- Police reports

Circumstances Surrounding the Death:

On the morning of [redacted], this 19-year-old young person was found by family hanging in the basement of their home. Upon the arrival of emergency responders, it was determined that he had likely already been suspended for several hours and he was pronounced deceased at the scene.

This young person was reportedly last seen by his family the previous night around 10:00 pm. At that time, he had been notified that someone had made sexual assault allegations against him and was told that as a result the police would likely become involved.

The post mortem examination confirmed the death to be a result of the complications of hanging.

Cause of Death:	Asphyxia by Hanging
Manner of Death:	Suicide

LDRT Findings Summary:

This young person was an Indigenous youth who was born in [redacted] but lived most of his life in [redacted]. He and his family were members of two northern Ontario First Nations. He was a kind, sensitive and resilient young person with a notable sense of humour.

At 4 years old, he was referred by his family physician for a developmental assessment due to speech, behaviour and overall development concerns. He subsequently began recurring Speech Language and Occupational assessments and therapies and was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), along with evidence of other developmental delays.

This young person started school shortly after turning 6 years old and began demonstrating significant improvements in various aspects. However, even with the historically identified developmental and behavioural challenges, his teacher and mother agreed that their biggest concern at the time was his apparent low self-esteem.

Just prior to turning 7 years old, this young person moved from [redacted] to [redacted], [redacted] with his (pregnant) mother and older sibling. His biological father seemingly remained in [redacted] for some time after that. Within a month of their relocation, his mother proactively referred to the child and youth mental health multi-service agency in their new community to seek some of the ongoing supports and therapies that they had previously been involved with.

After a month of beginning counselling services, the family's first referral to the local child welfare agency was made by the counsellor. Through their initial sessions the family disclosed historical experiences of domestic violence prior to leaving their previous community. This young person specifically had disclosed experiencing bullying and physical discipline by his father and acknowledged that this was not "okay". Given that the family had since moved away from that environment and were actively engaged in counselling services, the child welfare agency did not proceed with an investigation.

In this young person's first year of school in [redacted] (grade one), an Educational Assessment determined that he ranged well below average in various abilities and concluded that he would likely need Special Education support throughout the years. Three months later, an Individual Education Plan (IEP) was developed, although he was not yet formally deemed to have an exceptionality (e.g. learning disability). Despite many identified areas of need, he was noted to have strong social skills and sense of humour. At that time, he was also re-integrated to recurring Speech Language and Occupational therapies.

One year later, upon IEP review, this young person was identified as 'exceptional' with a mild intellectual disability. He was provided various instructional and environmental accommodations and access to Special Education and school-based Speech/Language Pathology professionals as required.

At 9 years old, he had a Neuropsychological assessment and was diagnosed with Fetal Alcohol Spectrum Disorder (FASD) and a Learning Disability. Recommendations were made regarding the necessary supports and accommodations that would be required in the school setting including ongoing Occupational therapies. The subsequent IEP review several months later reflected changes to the exceptionality identification to including the Learning Disability diagnosis. This young person was also approved for school-based Occupational therapy support for the following school year. The IEP was seemingly reviewed and implemented on a yearly basis for the remainder of his educational career.

In addition to the various developmental supports and services this young person was involved with, he had also continued counselling services with the children's mental health multiservice agency. At 10.5 years old he was recommended for bi-weekly counselling sessions to address coping skills development for anxiety. A further review 6 months later further indicated that the regular sessions be maintained to additionally address expression of feelings, self-esteem and worry management coping skills. These findings may indicate that he may have had emerging mental health concerns and/or was feeling overwhelmed.

As this young person was approaching 13 years old, an anonymous referral was made to the Indigenous child wellbeing agency indicating that this young person and his siblings had been

left in the care of their biological father whom had a history of being abusive. The agency subsequently conducted a joint well-being check with the police and the allegations were verified. A child protection investigation was opened and a month later a Safety Plan was completed with the children's mother. Six months later the child protection file was closed due to progress made in addressing the issues of concern.

A year later, another anonymous referral was made to the Indigenous child wellbeing agency over concern for this young person and his siblings related to their supervision and suspected substance use of adults in the home. A home visit and Safety Plan were implemented with support from maternal family members. The file remained open to ongoing services due to the concerns being verified.

Two months later a referral was made by police due to similar concerns and the children were deemed 'unsafe', however again maternal family members were supportive and determined to be a 'safe place' for the children as necessary. This young person disclosed that he felt safe in his home, except for when his mother's partner was present.

Through the agency's further investigation, this young person's teacher was consulted on his wellbeing and confirmed that This young person had been in "good spirits" and attending class every day. However, his grade 8 final report card indicated he had recorded 28 total absences.

Over the course of the next several months, various referrals were made on behalf of the children's wellbeing and provision of basic needs, substance use in the home and supervision concerns. Historically, the referrals were interchangeably directed to both the mainstream child and family service agency and the Indigenous child wellbeing agency. However, the family unit primarily fell within the latter's jurisdiction and as such there was often coordination and transfer between the two agencies. Following numerous home visits and reviews of Safety Plans, this young person and his younger sibling were voluntarily admitted into care via a Customary Care Agreement.

They remained in the care and home of family friends for approximately 6 months, with regular contact and visits with their mother. This young person initially did well in the placement however as time progressed there were reports by his caregivers and siblings of increasing aggression and behavioural concerns.

During this time, he disclosed to his foster caregivers that he was a victim of both physical and sexual abuse as a young child. This disclosure was referred to the Indigenous child wellbeing agency and the police and within a few weeks he was assigned to engage in services with the local children's mental health agency.

After 6 months, this young person returned to his mother's home under a Supervision Agreement. The ongoing Plan of Care established a variety of goals for this young person including but not limited to improving school attendance, managing emotions, and developing his identity and understanding of his culture. It is unclear to what extent those goals were meaningfully acted on.

For the next year and a half, he continued regular counselling sessions with the children's mental health agency while the family was also continuously supported by the Indigenous child wellbeing agency. There were at least two occasions of reported domestic violence between his mother and current or former partners, however this young person nor his younger siblings were determined to have witnessed the incidents.

As a mid-teen, this young person was involved in the discovery of his step-father's death by suicide in their family home and assisted in the resuscitation efforts. Following the incident, the family temporarily relocated to a relative's home and the Safety Assessment deemed the children to be 'Safe with Intervention'. In his following counselling session, he denied that the incident had any effect on his thoughts and disclosed that he was trying not to think about it.

Over the next several months this young person got a part-time job, had significantly reduced the number of recorded school absences, and was passing all of his grade 10 courses. The family continued to do well with various supports in place and around the time of this youth's 17th birthday, the Indigenous child wellbeing agency closed the family's file.

However, shortly after a theme of missed and/or rescheduled appointments with his counsellor ensued. Approximately 7 appointments were missed over the next several months and subsequently this young person's file with the children's mental health agency also officially closed. The documented reasons for closure were that his service goals were "met" and that as he would soon be turning 18 years old, he would no longer be eligible for their services. This young person did not turn 18 years old until approximately 6 months after the documented file closure.

Around that same time, he had also began demonstrating regression in his successes at school. By the conclusion of grade 11 he had recorded an approximately 50% absence rate and was unsuccessful in passing numerous courses. His report card indicated a recommendation was made for Credit Recovery through the Guidance Counsellor, however the review of available materials does not demonstrate what actions were implemented to address this issue.

Three months after turning 18 years old, he was arrested for Possession of a Schedule II Substance following a R.I.D.E. (Reducing Impaired Driving Everywhere) program check where he was found with marijuana and related paraphernalia. He was released on an Appearance Notice and required to appear before the court in 2 months later. The available records do not confirm the outcome of the charge.

This young person's first semester report card in grade 12 indicated he was doing exceptionally well in his Co-Op placement course but was unsuccessful in others – with again an increasing number of absences. Two months later, he was de-enrolled from school due to excessive consecutive absences. The available records do not indicate any measures taken on behalf of the school to reintegrate this young person to the school system.

Following this, it appears this young person was no longer engaged with any child and youth, Special Needs, or community supports or services.

Family Perspective*:

Insights gained from this young person's family represent him as an introverted and kind person who thrived in certain settings or circumstances. He thoroughly enjoyed travelling to the big cities with his family and friends, and voluntarily participated in a provincial youth project that highlighted the stories of young people living with special needs.

His family perceives the available child, family and community services to be lacking an important "human" aspect - while their intentions may be of a good nature, they often seem to "stock-pile" an individual or family's problems. This young person's family believe that regardless of his lengthy involvements with various services, for example the education and child welfare systems, the professionals providing those services did not truly know the "real" him. Additionally, their understanding is that in turn he did not trust those services.

This young person's family also understand there to be a significant gap regarding the meaningfulness and availability of FASD supports and services across the province, including in northern regions. Acknowledging the available research on the sexualized behaviours affected young people with FASD, this young person's family urge that there are no treatments available to specifically address these needs and that he would have benefitted from a "good" risk assessment, but this was unavailable – the service sectors need to better understand and address the complexities of FASD and the young people and families affected by it.

**This reflects only some of the perspectives gained from only those family members that were willing and/or available to participate in the review process and does not reflect the views of all existing family members.*

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LDRT Analysis

Key Issues Identified:

- Developmental and behavioural disorders and impact on life and social interactions
    - This young person was diagnosed with Fetal Alcohol Spectrum Disorder (FASD) and Attention Deficit Hyperactivity Disorder (ADHD) since young childhood and had historically received various therapies and was prescribed medications to manage these special needs.

- Addressing sexual needs, allegations of sexual assault and/or abuse and potential interactions with any part of the justice system
    - This young person was allegedly both a victim and a perpetrator of sexual assault and/or abuse over the course of his life and seemingly struggled with appropriately managing his sexual needs.
    - The thought of potential interactions with the justice system as a result of any of these allegations may have induced anxiety, fear and distrust, among other concerns.

- Disconnect from community services including but not limited to education, child welfare, mental health and developmental services
    - For the few years preceding this young person's death he had been disconnected from the service sectors that had historically been quite regularly involved with him and his family.
    - The review of available information did not identify involvement of any community services or support systems (outside of his family) at the time of his death nor the period leading up to it.
    - While this young person was historically involved with various services and supports throughout child and teenaged years, these seemingly abruptly discontinued as he approached adulthood.

Supplementary Concerns Identified:

- Lack of culturally-sensitive and FASD-specific supports and services across multiple community and child and family service sectors including a particular gap in acknowledging and addressing the life stages

- Lacking acknowledgement and education of the sexualized behaviours that can be associated with FASD, particularly in children, youth and emerging adults
    - Individuals with FASD are known to be affected by inappropriate sexualized behaviours and often, for various reasons, these concerns are not appropriately addressed.

- The available records indicate the topics of sexual needs and appropriate sexual behaviours were minimally addressed with this young person throughout his interactions with various services.

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Recommendations

Resulting from the review of available materials, the local death review table (LDRT) collaboratively with the Office of the Chief Coroner (OCC) make the following recommendations:

To the Ministry of Education:

1. *To review and revise existing policies related to student absenteeism (e.g. the Prolonged Absence policy) to include a meaningful process of ensuring mandatory student well-being checks before consideration is made to retire the student. Also, to reconsider, and even omit, the requirement of medical notes to support the student's absenteeism. This to ensure efforts to re-engage and re-integrate the student to the school system are made to the fullest extent.*

2. *Additional efforts be made to re-integrate specifically students with diagnosed mental health concerns, developmental delay, and those deemed exceptional or Special Needs, regardless of their age.*

This young person was de-enrolled (or "retired") from school in grade 12 following excessive consecutive absences as per the existing policies on student absenteeism. As he was 18 at the time and not of the "compulsory school age", the school would have been restricted from contacting his parent/guardian in efforts to have him return to school and would not have been required to refer to the Attendance Counsellor[i]. Because of this, once he was de-enrolled, supports from education staff would not have been available to him. The extent of efforts made by the school to re-integrate this young person were not evident in the review of the available records.

Further, the LDRT learned that this young person would have been required to produce a medical note addressing his absenteeism to be re-enrolled into the school. There is evidence indicating the negative impact that requiring medical notes can have in various settings, whether it be work or school. Some of these widely known issues relate to economic and geographic barriers including cost, accessibility, wait times, and overall burden. While the LDRT could not find evidence that this explicitly related to this young person's experience, it is possible that the requirement of producing a medical note would have added to the hardship and discouragement he was already facing.

For students such as this young person with documented developmental delay and potential mental health concerns, absenteeism could be a risk factor, and communication attempts by the school staff could contribute to the prevention of crisis situations. Additionally, students living with challenges similar to this young person's in particular could likely benefit from continuation of the stability and support that the school, classroom and peer interaction can provide.

To the Ministry of Education:

3. *To develop and implement specialized Fetal Alcohol Spectrum Disorder (FASD) education programs in both elementary and secondary schools across Ontario (like the [redacted] program of the [redacted] School Board), including a service transition plan for students transitioning from elementary to secondary school and beyond, and following the particular life stages of individuals with FASD.*

    a. *Consideration to be given particularly to school systems in areas of Ontario where FASD may be more prevalent and where these specialized education programs may be of greatest need and impact.*

To the local public district school board:

4. *To resume the [redacted] program within their schools in [redacted] Ontario.*

The LDRT learned that there is no long-standing support available for children and youth with a FASD diagnosis in Northern Ontario. Students with this diagnosis could benefit from education programming that specifically addresses their unique needs and life stages, throughout the entirety of their education from junior to senior level. The LDRT learned that the local public school board does provide FASD-specific programming however that programming is no longer available in the schools within this youth's community.

This young person was in this specialized program while in elementary school however when he transitioned to high school the programming was no longer available as it is only offered at the elementary level. The abrupt discontinuation of this program at the conclusion of elementary school indicates that a more meaningful and sensitive transition for students may be beneficial as they move into secondary school.

It is unclear if specialized FASD education programming is offered broadly across the province and the LDRT was of the opinion that students of any age living with FASD anywhere in Ontario could benefit from it.

To local public district school board and the local Community Living branch:

5. *To collaboratively review existing policies and protocols for planning, coordinating and providing FASD students/clients with consistent and culturally-appropriate supports throughout the life stages. If such policies and protocols do not currently exist, to collaborate to develop and implement, with Indigenous knowledges prioritized throughout and in recognition of current research that suggests consistent, culture-based and wraparound services are essential for the success of Indigenous people living with FASD.*

a. *Establishing clear plans and priorities may be important in seeking support as suggested in the corresponding recommendation below*.

To the Government of Ontario and the Government of Canada:

6. *To collaborate on supporting the identified needs of the organizations in [redacted] (and elsewhere) that are responsible for providing FASD services throughout the life cycle, including but not limited to resources and financial needs and constraints.*

To the local Community Living branch:

7. *To collaborate with Indigenous and non-Indigenous service providers on developing, or enhancing existing, wraparound programming that focuses on the life stage transitions of Indigenous youth living with FASD. This programming must be rooted in Indigenous knowledges about life stages and begin relationship building between the individual (and their family) and the Community Living branch at a young age, fostering the relationship throughout the life stages to help ensure that it will be trusted and relied upon when the appropriate life stage is reached.*

The LDRT learned that the Community Living branch has a mandate to provide transition planning for students aging-out of the school system, with a focus on building relationships. However, it was also evident from reviewing this young person's life that Indigenous youth in particular are "falling through cracks" with devastating consequences. Many FASD supports currently under-serve those living with FASD irrespective of their life stage, which is illustrated in this young person's life experiences. For example, FASD supports may be available while a youth is in the public school system but subsequently there is a lack of meaningful mechanisms for continued and on-going support. This suggests that the social support system does not entirely understand the needs of people living with FASD, in that their development stages are dramatically different than those living without a lifelong brain-based disability.

Research suggests that FASD services should be focused on providing services that are wraparound, age appropriate and consistent with cognitive capacities. Wraparound service delivery helps to ensure that FASD-specific services are seamlessly integrated within the lives of the family and young person affected by FASD, without which the services are unlikely to be engaged consistently, resulting in various negative outcomes (e.g. 60% of people with FASD become involved with the criminal justice system; 90% experience mental health challenges)[ii].

This young person's last remaining "service" prior to his death was the school and after he was de-enrolled there appeared to be nothing in place for him. Significantly, his counselling with the lead mental health agency had also already ceased. The LDRT was of the opinion that had there been continued supports for this young person after he was de-enrolled from high school,

for example a FASD support person to guide and support him through transitions in life stages, he may have been better able to access supports for managing sexual needs, suicidal ideations and/or other challenges. Particularly for youth with developmental disabilities such as in FASD, consistent and supportive relationships are critical. Additionally, for Indigenous youth such as this young person, the supports and services need to be culturally appropriate. The schools and Community Living have responsibility for transition planning and could better collaborate to ensure youth like this young person are not overlooked.

To local lead Children's Mental Health Agency:

8. *To reflect on the organization's transition and discharge approaches from a lessons-learned perspective, including a review of the 'Community-Based Child and Youth Mental Health Program Guidelines and Requirements', to ensure the most sensitive, compassionate and culturally-appropriate approaches are taken and remain paramount during file closures and cessation of professional relationships with children, youth and their families.*

9. *To identify whether there are FASD and Indigenous-specific best practices in managing file closures and cessation of professional relationships. If this does not exist, the agency should collaborate with Indigenous and non-Indigenous service providers in developing this approach to help ensure that the needs of Indigenous youth and families who are impacted by FASD continue receiving psycho-social supports.*

To the Ministries of Children, Community and Social Services (MCCSS) and Health (MOH):

10. *Consistent with the principles of prevention as outlined in the Child, Youth and Family Services Act to develop and/or enhance policies and programs for FASD prevention and the supports available to parents/caregivers of children and youth affected by FASD and other developmental disabilities.*

This young person and his family had a longstanding relationship with the Children's Mental Health Agency throughout the course of his life, including FASD supports, various therapies and counselling, etc. His services with the Children's Mental Health Agency ended as he was approaching 18 years old (the age limit for services) and because his "counselling goals were met".

The LDRT was of the opinion that a more sensitive and evidence-based transition approach could have been beneficial for this young person, as he transitioned out of the Children's Mental Health Agency's services and into emerging adulthood*, to ensure opportunities to continue existing relationships and/or access to other supports were explored to the fullest extent.

A sense of “connection” and meaningful, consistent relationships are important for children and youth, particularly those like this young person with developmental disabilities and those with mental health concerns, as is their sense of importance and belonging. As this young person was in his final years of high school and did not have any other known support systems in place aside from his family, the relationships he had built with the professionals at the Children’s Mental Health Agency may have been unassumingly important as he navigated the last years of his life and the events that unfolded.

As multiservice agencies in Ontario like this Children’s Mental Health Agency provide broad services including but not limited to developmental, child welfare, and mental health services, they likely work with both MCCSS and MOH. Therefore, it may be most appropriate for both ministries to collaborate on strengthening province-wide supports throughout multiservice child and family service agencies, particularly related to FASD and other disabilities.

* *The developmental life stage from late adolescence to early adulthood (16-25) is referred to as emerging adulthood (EA). This stage is also when early symptoms of diagnosable mental health problems and illnesses most often emerge. It is also when EAs face the most barriers in accessing service and supports*[iii].

To the Ministry of Education:

11. *To expand Graduation Coach programs across the province ensuring meaningful adaption and implementation by all publicly-funded schools in Ontario, both elementary and secondary.*

Graduation coach programs started as a pilot and observed various successes including increased credit accumulation and graduation. The program offers a “caring adult” concept, focusing on relationship building with students including making connections for them to community supports, school administrators, etc. Currently, such pilot programs are known to be offered only in high schools and for Indigenous and Black students.

The local public district school board’s Indigenous grad coach pilot program was not available when this young person was a student, however the LDRT was of the opinion that it could have been beneficial for him. As noted by family and peers, school was a source of social interaction for him therefore the connection and relationship-building aspects of the graduation coach program may have provided an incentive for him to continue attending high school to its completion.

As graduation coach programs are understood to provide a variety of meaningful benefits for students, particularly for Indigenous students in Northern communities, the LDRT was of the opinion that such supports and guidance should be available for students of all grades, not just high school, and could be particularly important during the transition out of elementary school.

To the Government of Ontario (specifically the Ministries of the Attorney General and Children, Community and Social Services) and the Government of Canada, in collaboration with both Indigenous and non-Indigenous service providers:

12. *Consistent with the Truth and Reconciliation Commission's Calls to Action #34, to develop Indigenous-specific FASD supports within the justice system that are grounded in Indigenous knowledges and consider the strengths, capabilities and needs of Indigenous people living with FASD. Where the supports exist, identify how they can be enhanced and better integrated within the network of supports that are currently available to Indigenous people and families impacted by FASD to help ensure that it is a trusted and accessible resource.*

13. *With reference to recommendations # 5-7 listed above, to ensure that justice system education and supports are integrated into the network of wraparound services that are enhanced or developed for Indigenous people and families impacted by FASD.*

This young person's death followed him being informed of allegations that he had sexually abused an individual and would possibly need to move out of his home to help ensure the safety of others in the home. The LDRT inferred that fears related to an investigation and loss of social supports were likely catalysts in his decision to end his life. The LDRT also recognizes the history of distrust that Indigenous peoples may have towards the criminal justice system. With these recommendations, the LDRT envisions responsible, sensitive and culturally appropriate justice system supports that can be accessed by individuals living with FASD and/or their families.

Estimates indicate that 60% of people with FASD encounter the justice system during their lives, and up to 90% experience mental health challenges[ii]. Because of this prevalence, it is important that wraparound services available to Indigenous families impacted by FASD include education and resources about the criminal justice process as well as the Indigenous-specific supports available to families through challenges associated with the criminal law. Had such supports been available to this young person's family, it is possible that a more nuanced approach could have been taken to beginning the conversation about the allegations against him and his housing options.

To all the local child, youth and family services agencies:

14. *To consider and assess the potential benefit and/or need of adopting Coordinated Service Planning with each client and family affected by complex, special or multiple service needs to the fullest extent.*

Although coordinated service planning in Ontario may have been only recently implemented prior to this young person's death, the LDRT was of the opinion that he and his family could have potentially benefited from an approach to coordinated services support as he was often

concurrently involved with multiple services over the course of his life. The LDRT identified that this could be beneficial to other children, youth and families in this community with similar circumstances and realities to that of this young person's, by providing an organized and informed approach to managing needs and ultimately providing relief or reduced pressures for parents/caregivers trying to navigate the service systems while meeting the needs of their children. It may be helpful if coordinated service planning was at least explored with every child/family in need of multiple services and supports.

To the Ministries of Children, Community and Social Services and Education:

15. *To consider making the inclusion and participation of educators compulsory in Coordinated Service Planning relating to students of the publicly funded school system.*

The LDRT recognized that education professionals have extensive and unique knowledge and understanding of their students and their students' needs, and that as students typically spend the majority of their days within the school and classroom setting, that front-line education professionals could be paramount to contributing to needs and service planning.

Although 'coordinated service planning' in Ontario may have been only recently implemented prior to this young person's death, the LDRT was of the opinion that he and his family could have potentially benefited from an approach to coordinated services support as he was often concurrently involved with multiple services over the course of his life. Further, the public school system was a significant component of this young person's services and supports, particularly addressing his FASD and ADHD needs among others, and since the school system was so involved and knowledgeable of his circumstances, that they would have likely been a significant contributor to 'coordinated service planning' had it been available. Educators can and should play a key role in the coordinated approach to servicing children and youth like him and addressing and understanding their individual and family needs.

To all the local child, youth and family services agencies:

16. *To develop a community of practice (CoP) among the sectors and service agencies that provide services to children, youth and emerging adults in [redacted] Ontario.*

17. *To include the "voice" of children, youth and emerging adults (both Indigenous and non-Indigenous) by incorporating representatives of these age groups within the CoP.*

The service sectors and professionals represented at the LDRT were of the opinion that enhanced knowledge about policy, programs and operations from peer organizations would improve their ability to collaboratively provide services to children, youth and emerging adults. Developing a community of practice can minimize silos between service sectors.

The LDRT identified that there are no existing multidisciplinary community tables or forums operating in this young person's community but that the community and the professionals that serve it could benefit from initiating a coordinated, multi-sectoral approach to identifying and addressing the needs of the children, youth and families that they serve. Specifically, some participants of the LDRT reported that the LDRT meeting was the first opportunity of their career to collaborate with their multidisciplinary counterparts at one 'table' to discuss issues and opportunities.

The LDRT was of the opinion that children and youth, like this young person, particularly in smaller northern communities could be better served and cared for if the community's service sectors engaged in regular, coordinated communication and planning.

The LDRT also learned from a group of Indigenous youth living in this young person's community that their thoughts, opinions and experiences could be critical to the identification of needs and the planning and coordination of the services they receive. As services aim to be child-centred, including youth representation may foster more meaningful understanding and acknowledgement of the best interests and perspectives of youth within the community.

To the Ministries of Children, Community and Social Services, Education, and Health:

18. *To collaboratively consider how to best devise a mechanism to sensitively address sexual health education and the sexualized behaviours that are often prevalent with FASD youth, providing them education and understanding of sexuality and appropriate sexualized behaviours so that they may be better able to appropriately manage their own thoughts, needs and behaviours.*

This young person's family expressed concern around the issue of addressing sexualized behaviours of FASD youth and a lack of appropriate treatments available in Ontario particularly for these youth.

Individuals with FASD have sexual needs like any other individual however they often lack the capacity and understanding of how to appropriately address these needs. Due to various factors, for example stigma or a false perception that individuals with developmental disabilities do not have sexual needs, these youth are often not appropriately educated on sexual health or how to manage their sexuality and this may result in inappropriate sexual behaviours. It is not uncommon for FASD individuals to be involved in inappropriate sexual behaviours as either a victim or a perpetrator, and it is understood that this particularly affects about 60% of FASD youth[iv]. Due to the allegations of sexual assault relating to this young person as both a victim and perpetrator, the LDRT felt that he could have benefitted from thorough and consistent support related to appropriately identifying addressing sexual needs and behaviours.

To the Office of the Chief Coroner:

19. *Request the recipients of these recommendations to report the results of their consideration of the recommendations within six months of receiving them.*

Potential Limitations of this Review:

This review was conducted through a pilot project exploring more wholistic and collaborative approaches to learning from the circumstances and interactions preceding a child or youth's death.

Not all service providers or service sectors involved with this young person throughout his lifespan were involved in this review.

Not all records relating to this young person and his interactions were available, used or identified for this review.

Not all family members were consulted for this review. The family members consulted provided only information of their choosing to the OCC.

Not all aspects of this young person's life and/or his interactions or involvements were included in this review and report.

[i] Ministry of Education. Enrolment Register Instructions for Elementary and Secondary Schools. http://www.edu.gov.on.ca/eng/policyfunding/forms.html

[ii] Green, C.R., Cook, J.L., Stewart, M., and A. Salmon. (2017). FASD and the Criminal Justice System. Canada FASD Research Network. https://canfasd.ca/wp-content/uploads/2017/02/FASD-and-the-Criminal-Justice-System.pdf

[iii] Mental Health Commission of Canada. (2020). Mental Health of Emerging Adults. https://www.mentalhealthcommission.ca/English/mental-health-emerging-adults

[iv] Anderson, T., Harding, K.D., Reid, D., and J. Pei. (2018). FASD and Inappropriate Sexual Behaviour. Canada FASD Research Network. https://canfasd.ca/wp-content/uploads/2018/07/CanFASD-Issue-Paper-Inappropriate-Sexual-Behaviour-Final.pdf