Child and Youth Death Review and Analysis Pilot

Local Death Review Table

Report and Recommendations

OCC File #: 2018-11906

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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.

Even though his family circumstances were difficult from a young age, this youth cared deeply about his mother, sibling, and other relatives. He was a caring and social youth, he felt things strongly, and cared deeply about what others thought of him.

Like most people, he wanted to be liked, but at times his mental health and accompanying behaviours made it difficult for those around him to relate and understand truly understand him. He cared about making friends, being treated fairly, and he yearned to be understood. He was seemingly gifted artistically, and his story-telling translated into a natural ability for the arts in both drama and visual arts, for which he excelled in school.

From a young age this young person struggled with mental illness, challenges at home, and the loss of a parent. He experienced harsh bullying and his behaviours were frequently not understood. Despite these factors he was strong and courageous in his attempts to seek help and to try and communicate, in his own, way what he was experiencing and feeling.

Despite challenges with the education system related to his learning and bullying that was often cruel and very hurtful, he was resilient. He found a place for himself in the online world and loved playing video games where he could engage, connect, and be himself in ways that he could not in other settings. When his peers struggled with their mental health he offered them support, despite his own challenges.

He coped with ongoing suicidal ideation from a young age, but he also had hopes and dreams for the future. He was excited about the potential for a future job placement and looked forward to the idea of working one day. Sadly, he did not get to fulfill this next stage of his life. However, he taught those around him the importance of friendship and relationships, and that finding a place of belonging in school and at home matters. He was talkative, a story-teller, and an artist of sorts. He cared for those around him including his friends that were struggling. This was a special young man that faced many hardships and challenges in his young life but also showed what it means to be resilient, caring, and compassionate. He will be deeply missed and while his struggles taught us so much we hope he will also be remembered for these strengths.

**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:

- Coroner's Investigation Statement (Form 3)
- Child Welfare records
- Children's Mental Health records
- Hospital records
- Ontario Student Record
- Police reports
- Post Mortem report

Circumstances Surrounding the Death:

This 15-year-old young person was placed in the care of a foster parent two weeks prior to his death. On [redacted], while at a cottage with his foster family he left to use the washroom and was absent for approximately 45 minutes. His foster brother went to find him and after several unanswered knocks he and the foster mother then unlocked the door with a knife. This young person was found hanging from a wooden beam by a belt. He was cut down and emergency services called. He was subsequently transported to hospital however vital signs remained absent throughout the resuscitation and he was pronounced deceased in the Emergency Department.

A week prior this young person had been assessed by the Crisis Intervention program. There had been a reported ongoing breakdown of the relationship with his girlfriend which led him to post suicidal content online. During that assessment, he denied intentions of self-harm and contracted for safety confirming he would notify friends, family, or '9-1-1' if he felt suicidal.

Cause of Death: Hanging

Manner of Death: Suicide

LDRT Findings Summary:

Born and raised in a northern Ontario community, this young person spent most of his life in a single-parent household. He was known to be an intelligent and artistic person who faced unfortunate challenges early on in his life.

This young person's involvement with the child welfare sector initiated at the time of his birth. Due to the mental health history of his parents, a Birth Alert was issued. The children's aid society ("society") considered apprehending him however did not on the condition that his parents had appropriate support systems in place. They were also referred to the Healthy Babies, Health Children (HBHC) program.

Within a week of their discharge to home, the society completed a home visit and identified no concerns. The HBHC program also confirmed no concerns with the family and baby. Less than six weeks later, the society file was closed.

Shortly after this young person turned 1 year old, a referral was made to the society by hospital staff regarding his father's mental health and alleged ideations of aggression towards his family. Upon investigation the allegations were not verified and two months later the society file was closed.

At 3.5 years old a referral was made to the society regarding a domestic violence incident. Upon investigation it was determined that this young person was not present at the time of the assault and that his parents had separated. The society file was closed at the intake stage.

At approximately 4 years old, this young person was assessed for the Early Years Mental Health Program by the local children's mental health agency. His mother reported behaviour challenges including temper tantrums and difficulty toilet training. The resulting treatment plan presented a week later included recommendations to support his mother with establishing appropriate expectations and providing parenting techniques for facilitating effective interventions. The clinical assessment was not declared complete until four months later and it remains unclear what actions, if any, were taken on the recommendations.

One year after the initial assessment this young person's mother again sought assistance from the children's mental health agency and a Child and Adolescent Functional Assessment was completed. He was reportedly exhibiting concerning behaviours socially and emotionally, including a fascination with human genitalia. His file remained opened until the age of 7.

In the middle of grade 1 this young person's school referred to the society reporting he inappropriately touched another student and disclosed physical discipline by his mother. The society's investigation determined the allegations to be unverified and after approximately one month the file was closed.

At 9.5 years old this young person's mother sought assistance from the hospital crisis unit indicating that he was grieving the recent death of his biological father and experiencing bullying at school. The Children's Crisis Assessment determined the risk level as moderate.

Just three months later his mother contacted police reporting serious bullying incidents. This young person was a victim of physical assault and threats by peers after school. The school Principal assured police that the matter would be managed internally. However, within two months this young person's mother re-referred to the police. The bullying worsened, and this young person reportedly disclosed fear of becoming a youth whom is "driven to suicide because of bullying". There is no indication of what action, if any, was taken by the school to manage this issue and this information is not documented in the student records as per policy.

Shortly after turning 10 years old, this young person was re-referred to the children's mental health agency for The Arson Prevention Program for Children (TAPP-C) assessment. At least one incident of fire-setting activity is evident from the available records. The TAPP-C assessment determined his behaviour to be 'normal pre-adolescent curiosity' and concluded that there was no indication for extra parental supervision.

The next school year, this young person's first Individual Education Plan (IEP) was developed. He was deemed exceptional and provided regular class resource support and accommodations. A psychological assessment by the children's mental health agency diagnosed him with anxiety, mild Attention Deficit Hyperactivity Disorder (ADHD) and deemed him highly emotionally sensitive. He was also noted to have an above average Intelligence Quotient (IQ) score of 117. Several recommendations were made to his school based on these findings including that his behaviours should be interpreted as a combination of ADHD, boredom and learned responses. The IEP continued through to high school.

At 12 years old, this young person was apprehended by police under the Mental Health Act following an incident of threatening suicide and violence at home and was admitted to the hospital's inpatient child and adolescent mental health unit. As a result of him disclosing previous physical abuse by his grandfather, a referral was made to the society and a protection investigation commenced.

Upon discharge from the mental health unit, his mother declared it would not be appropriate for him to return to her home. The next month, the society placed this young person in a kinship care agreement with an aunt in another province. This young person spent eight months in the care of his aunt, which is documented by both to have been a positive arrangement. He was taken off his ADHD medications during this time and reportedly did well. Although there were no concerns with his behaviours, his aunt declined to continue the kinship care agreement and after eight months he returned to Ontario to live with his mother.

A few months later, the family referred to the society following an incident where this young person witnessed an assault on his mother. During the investigation, this young person expressed anger regarding the incident and reported that it had been affecting his thoughts daily.

A short time after the society received an anonymous referral regarding inadequate supervision. While the allegations were deemed unverified, during the investigation this young person revealed his ongoing experiences of bullying at school by both peers and staff. The latter,

primarily in the form of what he perceived as negative comments towards and about him and being blamed for the actions of other students.

Four months later this young person was involved in a physical assault against his mother. He was subsequently apprehended by police under the Mental Health Act and admitted to the hospital's inpatient child and adolescent mental health unit. During assessment, he revealed increasing suicidal ideations resulting from exacerbating bullying at school where he was regularly called malicious names, attacking his mental and developmental capacity and unjustifiably targeting sexual identity. Two days later he was discharged and referred to the children's mental health agency. The risk assessment completed by the children's mental health agency reiterated that this young person's self-declared triggers for suicidal thoughts were his relationship with his mother and the 'bullies' at school, including a staff member.

In the two month period following the discharge, three referrals were made to the society including two from his mother and the police related to verbal and physical disputes at home. An interaction between the school and the society revealed a school staff member making statements suggesting that this young person brought much of his challenges upon himself and sought attention. This suggests that this young person's claims of bullying by professionals may have had legitimacy.

A subsequent referral was made by the school to the society after a classmate reported the suicidal content this young person had posted on social media. The mobile crisis team assessed him, deemed him safe, and developed a Safety Plan together with his mother.

A day after turning, this young person was apprehended by police under the Mental Health Act for a third time following an aggressive dispute with his mother. He was readmitted to the hospital's inpatient child and adolescent mental health unit and re-referred to the society. Following two days in hospital he was discharged to continue with supports in the community via the children's mental health agency.

At the conclusion of grade 8, this young person's report card indicated he recorded at least 35 absences and demonstrated increasing academic difficulties, particularly in the final term. For the start of grade 9, while this young person could have remained in his current school which offered both intermediate and senior grades, he transferred to a specialized high school well-across the city, primarily to escape the bullying.

Several months later an additional altercation at home with his mother led to the further involvement of police and other community supports including a Rapid Mobilization Table (RMT). The struggle in their relationship had seemingly made it increasingly challenging for this young person to remain in his mother's home. This young person revealed ongoing anxiety and suicidal thoughts and requested support from the children's mental health agency. The resulting Risk Assessment deemed the risk level to be low, indicating that this young person did not have a plan for suicide. A Safety Plan was implemented to support him as he remained in his mother's care. A month later the society filed was closed as the family was involved with various community supports.

Although not explicit in the available student records, information from collateral sources indicate that at the culmination of grade 9, this young person was notified that he would be unable to return to this specific school for the following school year due to truancy.

Over the summer months, the conflict in the home exacerbated leading to further involvements of the police and the society. The increasing conflict with this young person reportedly involved verbal and physical aggression, vandalism, and threats of suicidality. Due to the ongoing incidents of violence and difficulties managing his behaviours, his mother determined it would be unsafe for the family if he remained in her care and on several interactions with the society over a two month period, repeatedly requested assistance in placing him 'in care'. Subsequently, this young person was placed in a foster home via a Temporary Care Agreement (TCA) – approximately two weeks before his eventual death.

Following the placement, this young person made several unsolicited visits to his family's home resulting in negative exchanges with his mother, who was concerned with the safety of herself and younger child. Despite the tense recent history, this was seemingly disappointing for this young person as he was experiencing a significant life change such as being placed in foster care.

After a week in care, this young person's mother contacted the society and police for assistance after he sent suicidal messages to a family member. Following a wellness check this young person was referred by police to the Crisis Intervention program where he was not deemed an immediate risk. He admitted to suicidal thoughts but expressed he did not wish to die. The society's subsequent investigation determined both this young person and his foster mother reported the placement was going well. There is no indication that a Safety Plan was developed or revised at that time.

A week or so later, while this young person was on a trip with his foster family, he reportedly notified his foster sibling that his girlfriend had ended their relationship and he subsequently had intentions of suicide. The foster mother was informed of his disclosure; however, he was not immediately confronted as he had since gone to sleep for the night. The following day, this young person reportedly appeared in good spirits and the decision was made to address the suicidal disclosure after lunch. This young person left to use the outhouse facility twice, the second time not returning, before his suicidal disclosure could be addressed.

Family Perspective*:

This young person's family describe him as a highly intelligent and caring young person, his intelligence however also allowed him to be somewhat manipulative for example the ability to influence his desired outcomes in certain situations. He wanted to help others, in fact he was known by his family to have helped others with suicidal ideations but seemingly could not help himself.

His family understood this young person to have lacked meaningful connections. Though he was involved with numerous community services, he did not truly connect with these service providers in part because they often changed. The family perceive the inability of the service providers to connect with the youth they serve as an important factor.

As his family faced difficulty managing his behaviours in addition to their own individual challenges, they relied on the available community services to provide support and/or treatment to improve his wellbeing. This, in their opinion, did not happen.

The family identifies a need for providing supports for parents and caregivers, not solely the youth. That better outcomes may be achieved for youth, like this young person and others, if the family unit is better supported as a whole.

**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.*

Community Youth Perspectives:

In effort to explore meaningful methods of including youth perspectives and "voices" in the development of a more informed death review process, staff from the Office of the Chief Coroner (OCC) arranged a meeting with diverse youth from the community. With the assistance and support of a local child and youth service agency, several youth of various ages and backgrounds voluntarily participated in the meeting with informed consent.

The intent of the meeting was to explain the OCC's mandate and objectives of the Child and Youth Death Review and Analysis (CYDRA) project, ensure a safe space for thoughtful and sensitive discussion, and allow the youth to guide the discussions based on what they were comfortable sharing and what they wanted the OCC to know about youth experiences in the community today.

Some of the perspectives shared by these youth are reflected in the remarks outlined below:

- Youth awareness of suicide, suicidal ideations, and the signs of them is important. Preparing youth for situations such as mental illness and suicide will save lives.
- A resource is needed that youth in the community can call if they identify suicidal hospital.
- The key factor in suicide prevention is education and advocacy from a young age. If youth are taught to advocate for themselves (advocacy skills), it will decrease their social anxieties. Self advocacy should be considered a life skill and incorporated into the education system.

- The services for suicidal youth within the community do not feel "normal", or accessible; they are stigmatized; nobody wants to access them. Youth are reluctant to admit their suicidality out of fear of being hospitalized.

- All youth need to feel real connections; having meaningful connections is more helpful than being hospitalized.
- The inpatient mental health program restricts friendship and connection building; youth in the program cannot connect with each other as they might wish to.

- The family dynamic is missing in foster homes, group homes, etc. Youth in care need a loving, parent-figure.
- Youth in the community have been “kicked out” of foster homes because of their gender identity.
- Foster parents do not receive education on gender identity, sexuality, or the LGBTQ+ community overall. Education on these topics should be mandatory for foster parents and caregivers of youth in care.

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LDRT Analysis:

Key Issues Identified:

- Historical and recurrent experiences of bullying
    - This young person experienced escalating incidents of bullying, including physically and verbally, leading to the involvement of police and mental health and crisis intervention professionals.
    - This young person explicitly stated on various occasions that he understood his suicidal ideations to be directly correlated to the bullying he experienced.
    - The available details relating to the bullying incidents indicate that it could be reasonable to interpret these incidents beyond bullying, but as violence. There is anecdotal information that individuals known to be responsible for the bullying at the particular school are referred to within the community as the “suicide squad”—a group of youth within the school taunting and encouraging others to commit suicide. This information is known to local police and school board officials, including other community service providers.

- Lack of meaningful and therapeutic connection
    - This young person appeared to have a positive relationship with an aunt who he was placed with via a kinship care agreement, however the opportunity for that relationship to provide a long-term and supportive connection was likely impacted by his return to Ontario and the subsequent distance between them.
    - While involved with various service sectors, there were limitations regarding continuity of care and connectivity. For example, as evidenced by the children’s mental health agency there were in which many and various clinicians were involved in his care and there was not always continuity across treatment plans or a clear interdisciplinary approach.
    - This young person also reported experiencing treatment consistent with a bullying nature by various service professionals indicating that a therapeutic connection, rapport or relationship with some of those servicing him was likely absent.

- Familial conflict and/or tension
    - This young person demonstrated what can be interpreted as a tense relationship with his mother, evidenced by several incidents of verbal and physical altercations including the voluntary temporary placement in care.
    - The cumulative history indicates that supports were needed and would have been beneficial not just for this young person but for the family, particularly his primary caregivers. There is limited indication that any meaningful supports were offered to the family and primary caregivers from a family-centred approach.

Supplementary Concerns Identified:

- Monitoring of social media particularly related to suicidal content
    - On several occasions this young person posted suicidal content to his various social media platforms, including during the immediate period prior to his death. For some occasions there is evidence that peers reported the suicidal content to adults and/or professionals however there may have been other incidents that were not.

- Inadequate supports within education system, particularly related to mental health
    - Mental health resources are often limited within the school setting. Social workers or other mental health professionals are typically assigned to a group of numerous schools through which they rotate.
    - The records indicate that this young person had psycho-educational and other assessments done by the schools and that his education professionals were aware of his various diagnoses. Apart from the IEP with some classroom resource supports and accommodations, there is minimal record of mental health related supports offered in school.

- Multisectoral case management and information sharing limitations
    - The child and youth service sectors often operate in siloes and attribute privacy and information sharing limitations as barriers to cohesive multisectoral collaboration.

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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 children's aid society, the local lead children's mental health agency, the local hospital's child and adolescent mental health program, and the local public district school board:

1. *Engage an external reviewer to conduct a thorough and comprehensive internal organizational review of policies, service standards, and guidelines including all intersections with the deceased youth and their family.*

The LDRT noted opportunities for improved service provision and care amongst all involved organizations. The involved organizations could benefit from a thorough organizational review specifically related to the services provided and/or not provided to this young person and his family, particularly for the purpose of identifying and addressing lessons learned.

To the children's aid society, the local lead children's mental health agency, the local police service, the local hospital's child and adolescent mental health program, the Ministry of Children, Community and Social Services (specifically Youth Justice Division), the local public and Catholic district school boards:

2. *Develop a community of practice (CoP) among the sectors that provide services to children, youth and emerging adults and to include the 'voice' of children, youth and emerging adults by incorporating representatives of these age groups in the CoP.*

The service sectors 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. Additionally, 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 Ministry of Education:

3. *Review existing policies, legislation and/or guidelines related to OSR's and other records containing valuable student information and consider revising to allow the inclusion of mental health information. Specifically, to include documentation of all assessments, all decisions taken regarding placement and resources, social work involvement, bullying and violent incidents.*

4. *That mental health be considered a discrete category from Special Education.*

The LDRT noted that education boards and schools may informally record and retain important and valuable student information that is not required by the OSR Guideline and thus does not get transferred with the student as they progress through the education system. The LDRT learned that this young person had involvements with school social work and was a victim of bullying; this information was not included in the OSR and was not readily accessible to this young person's subsequent educators. Had this type of important information been available to all subsequent schools/educators they may have been better informed and prepared to appropriately meet this young person's needs and act on prevention measures.

5. *Review the existing elementary and secondary level curriculum related to mental health and identify opportunities to enhance education on identifying the signs of mental illness and substance misuse in peers and promote student-awareness of mental health and well-being. The review should inform the development of educational tools and/or resources that are accessible to all students, including outside of the classroom, to access help on these topics.*

Prior to the LDRT members of the Office of the Chief Coroner met with local youth in the community to hear their perspectives of the service systems. The LDRT learned from this meeting that education and awareness of mental health and illness from a young age could be beneficial and contribute to preventative measures. The local youth identified a need for the implementation of more concrete school-based education on mental health, suicide, substance misuse and the related indicators so that youth may be better prepared and able to identify and address these types of issues within themselves or amongst their peers.

To the local public district school board:

6. *Review the Ministry of Education's legislation and guidelines related to bullying prevention and intervention within the school system, particularly the Education Act, Part XIII, Policy/Program Memorandum No.144, the Accepting Schools Act, and the Keeping Our Kids Safe at School Act.*

7. *Review the school board's own response and plans of action related to addressing and managing bullying (e.g. the [redacted] School Board Bullying Prevention and Intervention Administrative Procedure Manual") to ensure timely updates and consistent implementation of equitable action plans within all schools.*

The LDRT observed a theme of recurring bullying throughout this young person's transitions between various schools within this school board. On several assessments by various multisectoral professionals, this young person explicitly attributed his mental health state and suicidal ideations to the extreme bullying he experienced at school. The records reviewed indicated the management of bullying and violent incidents within the school system were incompletely represented. There also seems to be an awareness within the community of an

apparent group of students within the board's schools being referred to as the "suicide squad" and this anecdotal information is deeply concerning.

To Facebook Inc. (includes Instagram, WhatsApp, Facebook and Facebook Messenger):

8. *Review their approach to detecting and responding to suicidal content posted on all their sites and platforms.*

The LDRT learned that this young person posted messages with suicidal ideation on social media platforms, particularly Facebook, in the time leading up to his death. A mechanism for identifying and alerting community supports of suicidal content on social media may help to intervene where necessary and potentially prevent deaths.

To the local lead children's mental health agency, the local police service, and the local public district school board:

9. *Collaboratively develop a policy to prevent, manage and respond to potential and confirmed incidents of bullying.*

The LDRT found that the occurrence of bullying incidents and their management were incompletely represented in the records it reviewed relating to this young person and the services he interacted with. The LDRT learned that this young person was a victim of bullying and that the multisectoral professionals serving this young person's community understand bullying to be a significant issue affecting their youth that may require a collaborative approach to addressing.

To the Ministry of Children, Community and Social Services:

10. *Review and remove restrictions to accessing mental health and development support services that may be currently only available to young people involved with the Youth Justice system and review extrajudicial measures (EJM) intake and case management processes so that mental health and other complex issues can be identified and supported as early as possible.*

The LDRT determined that young people in extrajudicial measures (EJM) diversion programs may not have access to or may not be appropriately identified for the mental health and support services that are available to young people involved with the Youth Justice system. The LDRT is of the opinion that EJM offers an opportunity for early intervention and all young people in need should have access to the same services and supports without requiring a direct involvement with the Youth Justice system.

To the Government of Ontario:

11. *Consider jointly establishing and developing a role within their ministries for individuals with appropriate training and experience to assist and support children, youth and emerging adults in their interactions with services that span across multiple service sectors. The role should operate from a person-centred approach, consistent with the child-centred approach in child and youth services and the patient-centred approach in healthcare.*

The LDRT noted that there were challenges in coordination, communication and collaboration for this young person and his family's interactions across multiple service sectors. The newly-developed role would ensure that all service providers work collaboratively across sectors in the best interest of the child, youth or emerging adult and with a consistent focus on their needs.

To the Office of the Chief Coroner:

12. *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 that they wanted to disclose 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.