Child and Youth Death Review and Analysis Pilot

Local Death Review Table

Report and Recommendations

OCC File #: 2018-8165

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 young person, it is important to share some sense of their strengths and uniqueness, so they are honoured for who they were in their life, before we examine the events and learnings surrounding their death.

This was a young adult who despite numerous challenges from early childhood, and throughout his youth, demonstrated resilience as he moved into young adulthood. While he struggled with many challenges, he also showed resilience in the face of learning disabilities, a school environment that didn't always support him in the ways he needed, a serious medical event, and a history of trying to cope with anxiety and depression. In the face of those complex issues he showed the courage to come forward and disclose an experience of sexual abuse that he had been silently dealing with since he was a child. Even though he had been through so much from a young age he pushed himself toward healing, he wanted what he saw as a path that was healthier – including moving on from using substances as a way of coping with pain or trauma. This was a tremendously courageous young man who opened himself up and showed vulnerability so that he could deal with the very challenging events of his past.

Despite challenges with his family he was close with them, even when he needed to rely on the Children's Aid Society as a form of support he remained engaged with members of his family, particularly his mother.

This young man was more than the sum of all his challenges, he was an incredible athlete. While navigating living in group homes, attending treatment programs, and trying to maintain relationships with family he was also giving back to other youth through his role as Captain on the high school sports team. This young man wanted a new start and looked for ways to find that for himself such as starting over at a new school. Despite road blocks and systemic challenges, he kept looking for the supports he needed, and in many ways was his own strongest advocate.

Over the next several pages you will read in detail about the struggles of this young person, and the complexities of their life that contributed to the circumstances around their death. As you read, we ask that you remember this was a youth who was fierce in his determination to find a different path for himself, while he struggled in young grades he used those experiences to bring youth together in sport, he was loved by his family and he loved them, he cared about a healthier lifestyle, he valued good food, and friends. While his life ended too soon, he taught us much about the lived meaning of resilience.

**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
- Community Health records
- Correctional Services records
- Ontario Student Record
- Police reports

Circumstances Surrounding the Death:

This young person was a 21-year-old emerging adult* who was living with his mother in [redacted] Ontario. In the afternoon of [redacted], he was found hanging with an extension cord around his neck and his shirt pulled over his head in the basement utility room of their home. His mother had last seen him that morning sleeping in bed prior to her leaving the home. The night before, he was reportedly agitated and upset.

This young person had a history of mental health challenges, criminal involvement and incarceration, drug and alcohol use, and had received services from multiple service sectors. Two months prior to his death, he had been released from custody under his mother's surety. As he had since been non-compliant with the terms of his release, e.g. missing work and not taking his medication, his mother was considering a withdrawal of her surety.

Toxicology reports indicated he had both alcohol and cocaine in his system at the time of his death.

Following his death, a note from this young person was found on a computer expressing an apology and implying he 'could no longer go on'.

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

**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*[i]

LDRT Findings Summary:

This young person was noted as a bright, sociable and kind person with great potential for success. He was known to exhibit innate leadership qualities and to be a skilled and passionate athlete.

At approximately 6-7 years old he was exhibiting concerning behaviours; he was reportedly aggressive, unpredictable and had interest in the interactions of older peers. In elementary school, problem-solving and conflict were frequently reported concerns and in grade one he was suspended following physical altercations (and again in grade three). At this time, this young person's family sought support from a children's mental health agency and was assessed at intake but two months later, prior to service initiating, withdrew citing the circumstances seemed to be improving.

Two years later, following the second school suspension, his family made another request for assistance from the children's mental health agency on the advice of his principal. A month later, the request was again voluntarily withdrawn before service had been initiated. This young person was reportedly not interested in participating.

When this young person was 11 years old, his family sought information from the children's mental health agency regarding his verbal and physical aggression, disclosing an incident where he had been restrained by a family member. Per the duty to report, the worker subsequently referred to the children's aid society ("the society"). The society did not open the file for investigation as there was no indication of injury or inappropriate force.

On his grades six and seven report card response forms, this young person stated having "a lot of out of school problems" and described his goal was to "not let his outside life affect his school work". The available records do not indicate what these statements may have referred to, nor if they were explored further.

At 13 years old, he was admitted to hospital with serious infections of the bone and blood, requiring significant medical interventions followed by several weeks of daily home care. This reportedly traumatic experience led to significant stress for him, including anxiety and fear of hospitals.

When this young person was 14, he voluntarily participated in the control group of a neurocognitive functioning research project with a children's hospital. The psychological report outlined his strengths, in addition to some weaknesses that were deemed consistent with a Learning Disability. The sharing of these findings with This young person's school resulted in the implementation of an Individual Education Plan (IEP) within two months. The IEP continued into high school, however there were inconsistencies in the exceptionality determinations of the subsequent IEPs as he transitioned between schools and grades.

By his 15th birthday, this young person had reportedly become increasingly aggressive and violent, was using substances, and was often sleeping out of home. His family contacted the society for assistance and the file was opened for investigation. A few weeks later, the file was closed as per his family indicating that sufficient supports were in place (it is unclear from the available records exactly what the other supports were). During this brief period, this young person had also been admitted to hospital for two weeks due to suicidality and was diagnosed with Post Traumatic Stress Disorder (PTSD) and Anxiety Disorder.

Two months later, this young person bravely disclosed to family and high school staff that he had experienced repeated sexual abuse by a relative (non-immediate), beginning at approximately age 7 and continuing for several years. Following this disclosure, he became involved with various community services which, variably, continued throughout the remainder of his life. He began sexual assault and trauma counselling, anger management therapy, became involved with victim services and again with the society. With support from his school, he also started attending classes less regularly while attempting to cope with his trauma.

This young person's family requested further support from the society, and while Safety Plans were developed and his family implemented life changes to reduce potential triggers, they ultimately decided that he might be better supported by entering temporary society care. This young person spent the following four months in the society's residential treatment group home (group home A).

While this was a significant transition for this young person, he reported understanding why his placement in the group home was appropriate and attributed the precipitating factors to be the sexual abuse trauma and use of substances.

While in group home A, he requested a transfer to a new high school to start grade ten, where he proactively contacted the coach of a school sport's team to join, of which he was later named Captain. On several occasions he requested unsupervised community and overnight visits with his family, to which the latter was denied out of concern that his resentment towards family related to the undetected sexual abuse would trigger negative interactions in extended periods of contact.

Half way through this young person's time in group home A, his experience and behaviours became progressively negative with note that the placement had 'broken down'. There were reports of anger and aggression towards peers, power struggles with staff, suspected theft and the presentation of six tattoos. He entered group home A with zero. This young person was suspended twice during this placement, for possession of drug paraphernalia and for uttering threats to school staff, the latter of which was for a period of 20 days. This young person had been negatively influenced in this group home, with reports of a specific staff member deemed responsible for enabling his substance use, tattoos, disappearances and overall deteriorating behaviour. A post-placement interview questionnaire later revealed that This young person reported continued personal contact with the staff member after leaving that home. A criminal investigation has since been initiated.

After four months, this young person was moved to a new group home (group home B), more than an hour away from his family. This group home provided more structure, support and was considered a more positive environment for him. Through this transition this young person maintained both trauma and anger management related counselling with the two organizations that had initiated following his sexual abuse disclosure. Attending these sessions required significant travel to and from the new group home, B. While the society also referred him to the local children's mental health agency, they denied service on the basis that he was already involved with other organizations and would not duplicate services.

This young person's move between the group homes also required a transfer between school boards. The receiving school board, providing education through the group home B, immediately requested a transfer of his Ontario Student Record (OSR). The OSR was not received until more than two months later indicating that his educational needs were inadequately addressed while his educators awaited receipt of his full educational history and records.

While in group home B, this young person advocated for quality gym access, healthier food options including the ability to purchase his own groceries and cook his preferred meals, and independent space to focus on school work. The society and the group home jointly provided for these requests. This young person was dedicated to his physical health and athletic performance, improved in school by achieving several credits since his move, and was noted to be a hard-working role model in the home. During this time, he also voluntarily testified in court against his sexual abuser and self-reported this to be a very stressful, but empowering experience for him.

Planning for the following school year, a meeting with this young person's previous high school was held to discuss his return. An agreement on an appropriate format for his return to the school could not be made. This young person wanted to return to regular academic classes, however the school did not agree and suggested a full-time placement instead. Alternative schools were explored to better suit his goal of attending regular classes and this young person subsequently enrolled in a different school board. In total, this young person was involved with 4 different boards and numerous schools before eventually attaining his high school diploma (at 21 years old).

In preparation for the planned discharge to his father's care, a referral was made to the children's mental health agency for joint counselling. This young person and his father agreed that this would be beneficial through the transition home. The agency notified his father that the approximate wait time for services was a minimum of 6 weeks. Six months later the joint counselling had still not initiated, and the file was closed at the request of his father.

After eight months at group home B, this young person was discharged to his father's care. The society supervision order was withdrawn a few months later and the file closed. For the

following year, there is no record of any significant events or services pertaining to this young person.

At 18 years old, this young person requested a Continued Care and Support for Youth (CCSY) agreement from the society for additional support while he lived with his father and remained connected to his mother. The CCSY agreement was renewed annually until he turned 21.

Several weeks after turning 18, this young person's involvement with the criminal justice system began. He was charged as a first-time adult offender for Robbery, Assault and Mischief. He was sentenced to 90 days imprisonment, 18 months probation and a conditional 9 months of community imprisonment with the initial 4 months of home confinement. Following the institutional imprisonment, he moved to [redacted], Ontario with his long-term girlfriend where he completed his house arrest and probation. This young person chose to move for a fresh start and to distance himself from negative peers, he was looking forward to positive life changes.

In his new community, this young person connected regularly with his Probation Officer (PO) and reported his experiences in both prison and the first group home as negative, claiming a staff member at the latter introduced him to drug trafficking. He continued working towards his high school diploma and successfully completed a five-week program targeting pro-criminal thinking and attitudes. He was even invited by a former group home worker to give a speech on his life and positive changes and reported to his PO that it was one of the "best experiences of his life".

After nine months he moved to live with his mother in [redacted] after a breakdown of his long-term relationship. He was involved in a second criminal altercation and in breach of his probation. He presented himself to police and was charged with Assault Causing Bodily Harm. He was sentenced to five months imprisonment and two years of probation. This young person spent the following two years periodically in custody, on house arrest or on probation for various charges.

While incarcerated, this young person proactively applied for and was accepted into a specialized five-month anger management and treatment program at a treatment and remand centre in [redacted] Ontario. This young person was optimistic that this program would be a positive-change experience as he completed his sentence. The program reports indicate that he demonstrated significant progress, attended all sessions in their entirety, completed all assigned homework, maintained an open-minded approach and provided honest input. He was making significant progress.

Two months into the program this young person was removed per a Judge's Order due to new charges related to incidents from several months prior to his arrival. This order required him to attend a preliminary hearing in Eastern Ontario. The transfer between correctional facilities took over two weeks and involved being held at several different facilities. The treatment program discharge report indicates that due to his early removal this young person was unable to

participate in several key areas of the program including but not limited to Relapse Prevention Strategies.

Following an additional two months in custody awaiting the preliminary hearing this young person was released on bail to his mother's surety and immediately reinstated regular meetings with his PO. This young person was reported to have done well on probation historically. He was noted by his POs to be amicable, positive and rarely missed appointments. This young person's PO was not consulted on his removal from the treatment and remand centre program and reported this as a very unfortunate and significant event in his trajectory.

This young person's CCSY agreement was terminated and the society file closed upon turning 21. Following his release on bail, he and his mother requested a CCSY Over 21 agreement for further support. A meeting to initiate the agreement was scheduled for 34 days after their request. This young person died two days before the scheduled meeting.

Eight days before this young person's death he attended a meeting with his PO and admitted to having stopped his medication for three weeks. The PO encouraged him to address his concerns with the medication's side effects at an upcoming doctor's appointment. The doctor's appointment was scheduled for 3 days after his death.

Family Perspective*:

The family's description of this young person highlights him as caring, compassionate, articulate and resilient. He faced devastating challenges by people and systems yet fought to overcome them. He was a young man who wrote letters from custody detailing his elaborate plans for positive life change and success as he worked on improved wellbeing and completing his sentence. He put great thought and effort into becoming a better person, acknowledging his challenges, and advocating for the support he needed and deserved.

In addition to the childhood sexual abuse, this young person's family strongly attribute the negative influences in the society's residential treatment group home and the removal from the treatment and remand centre program as cumulatively having profound impact on the trajectory of his life and subsequent life choices.

His family hoped that he be honoured for his resilience and kindness, and that positive change for others facing challenges within the education, child welfare and/or justice systems may come from reviewing and learning from this young person's life and experiences.

**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.*

LDRT Analysis:

Key Issues Identified:

- Delayed detection and/or disclosure of childhood sexual abuse
    - This young person disclosed the sexual abuse approximately 9 years after it is understood to have begun.
    - Family and educators did not identify indications that this young person was being abused prior to his disclosure.

- Experiences within the society's residential treatment group home
    - This young person self-reported this experience to be negative including that a particular worker introduced him to substance trafficking.
    - A criminal investigation has since been initiated.

- Inconsistency of mental health services throughout lifespan
    - This young person engaged in counselling with at least two organizations at the age of 15. The consistency and exact termination date of these sessions is unknown; however, it is documented that by age 19 he was no longer involved in any mental health therapy.
    - This young person's behaviours in school may have warranted mental health support had they been available. There is no record of any mental health supports within the school setting as having been available nor implemented.

- Removal from treatment and remand centre program
    - This young person was removed two months into the five-month [redacted] treatment program, in which he was demonstrating positive progress, and was transferred to a detention centre before being released on bail.
    - The police presenting the charge, the Crown Attorney and the Judge were likely unapprised of the treatment this young person was receiving and the progress he was making.

Supplementary Concerns Identified:

- Waitlists for children's mental health services
    - Children and youth can wait several weeks to several months to receive services, unless deemed 'urgent' at intake assessment.
    - Several attempts by this young person's family to access services were withdrawn before service had been implemented.

- 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.

- Inconsistency of Ontario Student Record (OSR) tracking and transfer
    - Student documents are maintained and transferred in paper form with no identified guidelines or requirements on timely transfer of these documents between educational institutions.

- Limited availability of treatment programs and/or facilities in correctional system
    - The treatment program this young person attended was a unique offender rehabilitation program limited to only select facilities across Ontario with limited capacity. Offenders accepted into such programs may be required to travel great distances across the province.

- Inconsistency of primary health care, particularly throughout institutionalization
    - This young person's access to consistent primary health care was limited particularly during his transitions in and out of society care and incarceration and between geographical relocations. For example, the family physician last assessed this young person approximately two years prior to his death.

- 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 Ministry of the Solicitor General and the Ministry of the Attorney General:

1. *Consider the transfer of individuals, in particular emerging adults[ii], in custody between institutions for procedural or administrative purposes in the context of the best interests of the individual and their current treatment and programming; including the consideration of remote attendance for hearings if permissible under the law.*

    a. *Consideration to be given to titling this approach [redacted] Principle".*

2. *Devise a mechanism to provide decision makers (e.g. Crown Attorney, Judge) with updated information (e.g. written documentation) on the individual's treatment programs and progress for consideration during the decision-making process related to hearings, scheduling, conditions, etc.*

3. *Emerging adults in the correctional system require specific understanding and approaches that are distinct from those required when dealing with incarcerated mature adults. Specific training for corrections staff should be developed to address this need.*

4. *Develop a person-centred approach to individuals in custody paralleling the child-centred approach in child and youth services and the patient-centred approach in healthcare.*

The LDRT noted that this young person's transfer from the treatment and remand centre for the purposes of a preliminary hearing led to him being prematurely discharged from a treatment program in which he was reportedly making progress and learning helpful coping skills. Had he not been obliged to travel to his preliminary hearing and/or had the Crown Attorney and Judge been aware of his success in the treatment program, his therapy and treatment could have continued, which may have prevented his death.

The LDRT noted that this young person became involved with the correctional system at a young age (within six months of turning 18) and simply because of his age would have less opportunities for help than he would have had access to if offending prior to turning 18. As the Mental Health Commission of Canada, and other institutions, refer to individuals up to the age of 25 as 'emerging adults' and often 'youth', the LDRT was of the opinion that persons of this age group involved with the adult criminal justice system should be managed according to their distinct status.

To the Ministry of the Solicitor General:

5. *Review the available treatment programs, treatment facilities and capacity province-wide in order to develop a plan that improves access to services for incarcerated persons, in particular emerging adults.*

The availability of family support is important for youth and emerging adults who are incarcerated. The treatment program that this young person attended at treatment and remand centre was unique (one of only approximately two of its kind in the province) and similar services or programs were not available closer to his home community and support systems. This geographical disparity contributed to the prolonged transfer between facilities to attend his preliminary hearing and the significant distance from his family.

To the Ministry of Children, Community and Social Services, the Ministry of Education, the Ministry of Health and the Ministry of the Solicitor General:

6. *Consider jointly establishing and developing a role within their Ministries for individuals of appropriate training and experience to assist and support children, youth and emerging adults in their interactions with services that span across multiple 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 significant challenges in coordination, communication and collaboration for this young person and his family's interactions across multiple service sectors, both youth and adult. 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 Ministry of Education:

7. *Review and/or enhance the requirements, particularly the timelines, for the transfer of the Ontario Student Record (OSR) and other pertinent education records between education institutions to minimize delay.*

8. *Develop a province-wide electronic record keeping system for the retention and transfer of the OSR and other important student information that may be accessible to and used by all education institutions, including Indigenous education authorities.*

The LDRT noted that the transfer of this young person's OSR from one education institution to another took several months, which prevented the receiving institution from promptly identifying and addressing his educational and mental health needs. In addition to the delay, the OSR was incomplete and not in compliance with the Ministry of Education OSR Guideline.

An electronic record system could facilitate immediate access to student records, particularly when a student transfers from one institution to another, and potentially eliminate any delay in educators accessing the student information they require to aptly support their students.

9. *Review, and where appropriate, develop or enhance training for frontline education staff to identify and recognize signs of mental health challenges, trauma, abuse, and children in need of protection, intervention, support or services.*

10. *Consider involving young people with lived experience in the development of the above-mentioned training for frontline staff.*

The LDRT noted, in retrospect, that this young person may have exhibited signs consistent with mental illness and/or trauma several years prior to the exacerbation of his behaviours and his voluntary disclosure of abuse. Enhanced training of education professionals and integration of mental health resources within the educational system may have allowed early identification and detection and prevented the delayed determination that this young person was experiencing abuse.

To the Ministry of Education and the Ministry of Health:

11. *Review existing resources and devise a mechanism to better connect students in the public school system with meaningful and accessible mental health resources, within the school setting and/or their community, from an early intervention approach.*

The LDRT noted that the school setting is where young people typically spend most of their time, therefore it may be an ideal setting to address early intervention and engagement if appropriate mental health resources and supports are made available. As this young person was exhibiting concerning behaviours while in school, it may have been timelier and more effective if he had access to mental health supports within the school system.

To the Ministry of Health and Ontario Health:

12. *As Ontario Health Teams (OHT) are developed, consider including incarcerated individuals, particularly emerging adults, so that they may receive consistent and improved care via an OHT throughout transitions between institution and community.*

13. *As OHT's are developed, careful consideration to be given to children, youth and emerging adults, particularly those in the care of child welfare, and their access to OHT's so that they may receive consistent primary care.*

The LDRT noted that transitions between custody and community adversely affected this young person's continuity of care. The available records indicate that he may not have had consistent primary health care, particularly throughout his involvement with both the child welfare and justice systems and the subsequent geographical relocations he experienced. Consistent access to a primary healthcare provider may have allowed for therapeutic relationship building and consistent following of his overall health and wellbeing.

To the Government of Ontario:

14. *In consultation with the Office of the Information and Privacy Commissioner, consider developing province-wide information sharing protocols that facilitate the sharing of information between ministries and their affiliated agencies, boards and commissions about young people in receipt of their services, to the fullest extent permitted by law, so that young people in need of intervention may be identified and supported early by coordinating the services they require to reduce the risk of possible harm or death.*

The LDRT noted that privacy considerations limited coordination, communication and collaboration for this young person and his family's interactions across multiple service sectors. The LDRT noted that there are provisions for gaining consent to share information under the CYFSA and other legislation however these provisions seem to be a barrier.

To the Ministry of Children, Community and Social Services:

15. *Following the resolution of any corresponding legal activities and/or court proceedings, to consider reviewing the service provided by the children's aid society's direct-operated residential treatment group home and the experiences of this youth as a result of residing there.*

Due to ongoing legal matters, the LDRT did not explore the incidents that may have occurred while this young person was residing at the residential treatment group home. As this may be considered a gap in the exploration of this young person's entire life circumstances, the LDRT was of the opinion that, when legally able, the oversight ministry could review the events that occurred within the residential treatment group home while it was in operation and its relation to this young person.

To the Office of the Chief Coroner:

16. *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. For example, this young person's Ontario Student Record (OSR) was not accessible to the Office of the Chief Coroner (OCC) until after the LDRT convened. These materials were cautiously reviewed following the LDRT meeting by OCC staff.

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.

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