Child and Youth Death Review and Analysis Pilot

Local Death Review Table

Report and Recommendations

OCC File #: 2019-13147

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 learnings surrounding their death.

This was a First Nations youth. He was proud of his community and was evolving and learning about himself, his culture, his identity. He was close with his family and siblings but had a special relationship with his grandfather.

This youth's community and family was impacted by a legacy of systemic inequalities and racism which meant that he faced many barriers and traumas in life. Despite these inequities he was loved and care for by his community and his family.

He demonstrated tremendous resilience by seeking support and help for the challenges that he experienced. It would not have been easy for him to reach out to those around him to seek help, or that admit he did not feel safe. However, many times he did just that, as he attempted to advocate for his own wellbeing in the ways he knew how.

He struggled in school and although his needs were continuously overlooked and unmet, he showed courage and resilience. At times, as his confidence built, he demonstrated interest in school and in his success again.

To those who knew him, his family and his community, he was unique and special. He loved music, he was in some ways protective of his siblings, he showed strength and courage in the face of inequity and adversity.

Some might interpret this as a somewhat withdrawn and reclusive young man, but those closest to him would urge this be reframed and understood from a lens of strength, courage and hope—a quiet and thoughtful young man, who was resilient, had great potential, and despite all barriers and let-downs, wanted his loved ones to be safe and well.

**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
- Police reports
- Post Mortem report

Circumstances Surrounding the Death:

In the very early hours of [redacted], an apparent body was discovered on the train track of a rail yard in [redacted] by the train engineer entering the yard. The train was stopped immediately, and police were called to investigate. Upon police arrival a few minutes later, a male body was confirmed under the train with obvious indications of death.

The post mortem examination confirmed the death to be a result of severe injuries and this 15-year-old youth's identity was subsequently confirmed via fingerprints. The toxicology analysis indicated a significantly elevated ethanol level indicating that he had consumed a considerable amount of alcohol prior to the accident.

This youth was reportedly last seen around in the afternoon the day prior, during his shift at a local establishment. He left to use the washroom and did not return. As the rail yard is located in between the place he was residing and the main part of town, it seems this youth may have been cutting through the railyard to shorten his journey.

Cause of Death:	Pedestrian Collision with Train
Manner of Death:	Accident

LDRT Findings Summary:

This youth was Indigenous and a registered member of First Nation A. He was born in Town A but moved several times between numerous communities in Northern Ontario, both on and off reserve. While noted to be a healthy and happy baby, this youth endured unfortunate individual, familial and social challenges from a very young age.

When this youth was an infant, his family became involved with the local Indigenous child wellbeing agency A in City A, related to a domestic violence incident and intoxication in the home. With the support of family members, this youth's mother sought assistance to temporarily remove her intoxicated partner from the environment as he posed a risk to the child, which was successful with the assistance of police. A Safety Assessment completed 3 days later deemed this youth 'safe' and considered the incident to be isolated. His parents were notably cooperative and affectionate, and the file was closed.

At a year old, this youth and his newborn sibling were living in First Nation A with their mother. A year later, a maternal family member referred to the local Indigenous child wellbeing agency B with concerns of lack of supervision and their mother's substance use. A day later a Safety Assessment deemed the concerns to be unverified, indicating their mother had made proper arrangements for childcare and was not regularly using alcohol.

At approaching 3 years old, the family appeared to be living back in City A. There was a brief involvement with the Indigenous child wellbeing agency A following an incident investigated by police that involved a physical altercation in the home involving alcohol use. Upon Safety Assessment the concerns were unverified, citing no protection concerns, and the file was closed at investigation.

Several months later, this youth was again living in First Nation A. A referral was made to the Indigenous child wellbeing agency B" by a maternal family member who had been caring for this youth since his mother left the community and had not returned. The referent indicated they would keep caring for him until a suitable placement was arranged but could not do so long-term. A child protection investigation initiated, deeming the children 'safe', however the children were shortly after taken to First Nation B to live with other family members (known to be this youth's god parents). They agreed to care for the children until their mother returned and the file was subsequently closed.

Two months later, this youth was returned to his mother's care. Several referrals were made to the Indigenous child wellbeing agency B by his mother at that time regarding her concerns with being able to care for him and exploring potential for him to be placed in the agency's care. A child protection investigation commenced, and the children were deemed 'unsafe'. At that time, this youth's mother was seemingly dealing with transient living circumstances among other challenges.

When approaching 4 years old, this youth and his sibling were placed in First Nation C for three months via a Customary Care Agreement. Following this placement, the children returned again

to live with this youth's god parents in First Nation B and the file was closed. It remains unclear exactly when the children were eventually returned to their mother's care.

Over the next several years, the family appeared to have lived in various communities of Northern Ontario. Numerous referrals were made to the Indigenous child wellbeing agency B related to concerns of inadequate supervision, substance use, and potential domestic violence. These referrals resulted in Safety Assessments that deemed the children 'safe' and in some circumstances were not opened for investigation.

At 10 years old, this youth was again living in City A. Several months later, a referral was made to the local Indigenous child wellbeing agency A related to his mother's inability to provide appropriate care as a result of substance use and the impacts of reported domestic violence. A Kinship Service arrangement was made with a family member nearby and the children were deemed 'safe with intervention'. During this placement, this youth disclosed feeling content with living with family but missed his mother. He was noted to be the "most upset" of the children in relation to being separated from his mother and community.

Through the Kinship Service placement, this youth's mother remained involved in the children's daily activities with a Safety Plan in place. Two weeks later, the children were returned to her care. For the following approximately three years, this youth and his family resided in City A and continued to be engaged with the child welfare system ongoing services.

Through this period, there were conflicting reports about this youth. His mother reported that she was struggling with concerns related to his behaviour. However, his grade 6 report card noted him as cooperative and pleasant, and demonstrating more confidence and self-direction in learning.

In the fall of that year, his mother self-referred to the Indigenous child wellbeing agency A following an argument they had which led her to using physical force out of frustration. She enquired about putting this youth in a treatment home. The subsequent investigation and discussion with this youth by the agency determined him to be "emotional". He reported unhappiness in the current home environment and a desire to return to First Nation B. His mother declined this option for various reasons including a belief that the education system in First Nation B was not at the standard of City A's and had previously passed him although he had not been meeting the requirements. Ultimately, the home was deemed 'safe' with a Safety Plan in place.

Over the next several months, several more referrals were made to both Indigenous child wellbeing agencies by this youth's mother, other family members and police. The concerns ranged from this youth's reluctance to attend school regularly, his mother's apparent mental health and substance use, and escalating conflict between the two of them. On all occasions the family was deemed 'safe with intervention'. During that period, this youth was seemingly de-enrolled from school as the family had intentions to move back to First Nation A. However, it appears that the relocation did not occur as planned and it is unclear when exactly this youth was next re-enrolled in the education system.

By 13 years old, this youth along with his siblings were again placed in a Kinship Service placement with the same maternal family member in City A following an unannounced home visit by the Indigenous child wellbeing agency A. The children were found unsupervised and the home to be unsafe. Days after the Kinship placement was arranged, this youth had returned to First Nation A to live in the care of his maternal grandfather. His mother and siblings joined him shortly after. As a result of the family's relocation, the child welfare file was transferred between the Indigenous child wellbeing agencies to reflect corresponding catchment areas. A few months later, Indigenous child wellbeing agency B closed the family file.

While living in the primary care of his grandfather, this youth was sent for a Math and Reading assessment just before turning 15 years old. As the assessment was unavailable in their community, he was sent to City A. The results of the assessment determined this youth was functioning between a grade 2 and grade 3 level in various categories. According to his age, this youth was meant to be in grade 9. The assessment made various recommendations including that he be enrolled in an accelerated program of at least 4 hours per week to develop and strengthen his skills.

This youth's grandfather subsequently issued a letter to the education institution in their community highlighting the findings of the recent assessment and the concerns with this youth's educational progress to date. As the complete student records could not be located for this review, it is unclear what actions, if any, were implemented as a result of this request for support or to address his identified needs.

Over the following year, this youth's behaviours reportedly became increasingly challenging for his family and caregivers.

During this time, he also underwent surgery in Town A for a serious medical condition. He recovered well in hospital and although he was given the option to remain there for further post-operative care, he wanted to return home to his community of First Nation A the following day.

A day after returning to the community, a Missing Persons report was made to police after this youth left the family home in the evening and did not return. Search efforts initiated by the police and an Emergency Response Team, however in the early hours of the following morning he returned home, reportedly dishevelled and intoxicated. He was apprehended by police and then released upon sobriety. Following this incident, this youth's grandfather requested he be placed in the community Safe House, however no further action was taken by police.

Weeks later, another incident arose leading to the police being called due to aggressive behaviour in the home. This youth reportedly damaged and vandalized the home. He was subsequently transported to the community Safe House and the family was advised by police to seek medical assessment regarding his behaviours. This youth subsequently discharged himself from the Safe House shortly after. At that time, the file was reopened with the Indigenous child wellbeing agency B after referrals from both a Special Needs coordinator in the community and the family as they reported conflict was escalating.

Again a few weeks later, police were dispatched to the family home after this youth used gasoline in a threat to light the home on fire. The involved Indigenous child wellbeing agency B did not follow up with the family on the incident until one month later. This delay was reportedly exacerbated by capacity challenges. During the period between the above mentioned incident and the agency's follow up with the family, this youth had also self-referred to the agency suggesting that he did not feel "safe" living in the current family home, however he did not provide reasoning.

Family disputes continued in the home relating to the ability, or inability, to care for and manage this youth's challenging behaviours and finally after months of challenges, a case conference was held with the family, community and Indigenous child wellbeing agency B. This youth's family urged that he needed to be placed in the agency's formal care in order to get necessary treatment and/or services. However, the decision was made for this youth to alternatively stay in the community Safe House while mental health assessment and treatment options were to be further explored, including accessing Jordan's Principle funding. The Risk Assessment completed shortly after rated the family as high risk.

Approximately 2 weeks later, a referral was made for this youth to be placed in a residential treatment program based on the apparent mental health concerns and aggression towards family. Additionally, a physician connected to his First Nation community issued a letter of advocacy to Jordan's Principle highlighting this youth's challenges and need for treatment.

Finally, nearly 2 months following the referral, this youth was placed in a residential treatment program on a voluntary placement following the approval of Jordan's Principle funding. While in Northwestern Ontario, the residence was an incredible distance from his home community and several hundred miles from Town A, where his mother and siblings had recently relocated to. The children's mental health agency had recently become involved to arrange a psychological assessment. However, despite being in the residential facility, he would still be required to travel to a nursing station to have the assessment done.

In only a few days at the residence, this youth ran-away at least twice leading to the initiation of police protocol and emergency response efforts. Both times he was found safe in the nearby forest and reluctantly returned to the residence. Staff from the residential treatment program reported that he initially presented as quiet and reserved but did on occasion socialize and interact with staff and peers. However, by day 3 he was declining group activities and appeared upset, particularly after making a call to family. After his first run from the residence, he expressed intentions to continue running until he was removed from the program. As the placement was voluntary, staff referred to family members (guardians) who urged the need for him to remain in the treatment although he remained adamant on leaving. There is minimal indication that an active plan was in place to proactively address his running behaviour or to address his desire to leave the program.

On the third day, this youth was removed from the residential treatment program by police and placed in protective custody. Through the coordination of the various service providers, he was placed in a motel under the temporary supervision of a local child welfare agency until being transferred to his mother's care in Town A about a day later.

On the same day of his discharge, a psychological assessment had been scheduled for nearly 3 weeks later and just 5 days after his eventual death. This was coordinated by the children's mental health agency and the residential treatment program and to be completed at a nursing station through the Ontario Telemedicine Network (OTN).

On the day of arriving in Town A, the Indigenous child wellbeing agency B prepared a Safety Plan with both this youth and his mother present. However, beyond that, while in Town A the extent of this youth's wellbeing and behaviours are largely unclear, primarily due to minimal interaction with any service providers, including the agency.

On the day before his confirmed death, the agency worker visited the family's temporary place of residence at a motel twice, but on both occasions this youth was not present. He was reported by others to be "doing well" and working at the same establishment as his mother and her partner.

After two days missing and failed search attempts, this youth's mother filed a Missing Person report and his death was subsequently confirmed. Despite the documented history of challenges, this youth did not appear to be meaningfully involved with any supports or services and although he was of the compulsory school age, had not been registered for school in Town A despite the new school year commencing.

Family Perspective*:

This youth's family shared immense grief and a history of hardships, including disappointment with the unnecessary barriers faced by various systems that failed to provide support and the circumstances leading up to his death. This youth was underserved and experienced a lack of accessibility, primarily by the systems meant to support children, youth and their families.

The family particularly emphasized the experiences with the child welfare and education systems. As they faced challenges with safely managing this youth's needs and behaviours, they looked to the child welfare system to provide support in protecting him and getting him access to the necessary services. Their understanding was that involvement with the child welfare system and potentially placing this youth into care would have increased access to programs and services. They also highlight that his educational needs were unmet due to barriers and challenges First Nation communities experience in relation to the education system.

Despite historically struggling with school and receiving a psychoeducational assessment that articulated the supports required to accommodate his learning needs, this youth was continuously moved through the grade levels according to his age without attention to his individualized needs. His school experience was reportedly distressing for him and was impacted particularly by a lack of accessibility to qualified education professionals.

This youth's family also shared the importance of interpreting his life in the context of their historical backgrounds, generational traumas resulting from the current and ongoing impacts of

colonization and their lived experiences. The family's hope is for meaningful change; and that the review of the unfortunate circumstances that this youth faced can contribute to learnings and inform changes that can positively impact the outcomes for other Indigenous youth and their families.

**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:

- Lack of professional assessment and diagnosis
    - Despite exacerbating behaviours and advocacy on the part of family and community members, this youth did not receive professional assessments related to developmental, mental health, and/or psychological matters and therefore did not have any diagnoses.

- Unaddressed educational needs and misplacement of Ontario Student Record (OSR)
    - This youth's OSR was not efficiently maintained and transferred between various education institutions and was unable to be located upon request for this review.
    - This youth struggled to attain success in his education and the issues seemingly went unaddressed for many years until he was sent by family to City A at 14 years old to be assessed.
    - The assessment determined him to be functioning at a significantly lower grade level than his age would suggest and identified specific learning needs.

- History of frequent residential relocation
    - This youth moved numerous times throughout the course of his life between various communities spanning Northern Ontario. This led to numerous changes in caregivers, service providers, and educational institutions as well as diminished access to and consistency of service.

Supplementary Concerns Identified:

- Familial hardship and associated impacts of intergenerational trauma
    - Various family members and caregivers reported challenging experiences ranging from conflict, relationship strain, substance use, bullying, physical and domestic violence. These complex life circumstances intersected with this youth's needs as they impacted him directly and yet service systems at times did not understand and address the totality of the issues that this youth and his family were experiencing in a wholistic manner.

- Inadequate availability of child/youth, family, and community services within Northern and remote communities (particularly First Nation communities) and accessibility to Jordan's Principle funding, resources, and other associated services
    - These communities, like several of those which this youth resided in, often have extremely limited services available and thus require children, youth and families to travel hundreds of miles to receive them, or to go without the services entirely.
    - Despite receiving Jordan's Principle funding shortly before his death, it was unfortunately after many months and years of accumulating and unmet needs

and challenges. Community members and service providers report First Nations peoples often face barriers to applying for and accessing Jordan's Principle.

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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 develop a province-wide electronic record system for the retention and transfer of Ontario Student Records (OSR) and other important student information that may be accessible to and used by all education institutions in Ontario including Indigenous education authorities.*

2. *To develop concrete requirements for the timely and expedient transfer of OSRs and other relevant student records between education institutions including Indigenous education authorities. This should outline a maximum time period for which such records must be transferred and received as well as accountability measures for the documentation of the individuals responsible for sending and receiving such records.*

This youth's complete student records (particularly his OSR) were unavailable for this review as none of the education institutions he previously attended (both public school system and First Nation education authority) were able to locate them upon demand from the Office of the Chief Coroner (OCC).

Similar to many First Nations youth who may not have access to services within their communities, this youth frequently relocated between First Nation communities and off-reserve communities across Northern Ontario, which required transferring records between various First Nation education authorities (federally funded) and provincially funded school boards. The relocations required a transfer of his OSR and other educational documents which due to the standard paper/hard-copy nature were required to be sent by post. Had there been an electronic system in which the education institutions could access and transfer the records amongst them, the likelihood of his education records being misplaced or lost would have been minimized.

The LDRT did not identify any existing requirements related to the timely transfer of student information between institutions. If clear requirements for the timely transfer of student records were developed and implemented, the risk of delayed record transfers and/or potential loss of these records could be minimized, thus improving accountability mechanisms. As student records typically contain great amounts of valuable and historical information, it is important that the quality and preservation of them is consistent and that relevant education professionals have timely and convenient access to such records in the best interest of the student and their learning.

The LDRT recognized that the risks of delayed or lost school records are more likely to impact First Nations youth from remote communities, as they are often required to leave their home

communities in order to attend grades 8-12. This risk is even more pronounced given intersecting realities that may impact some First Nations youth, such as intergenerational trauma, involvement with the child welfare system and other challenges. Nurturing the wellbeing and success of First Nations children and youth needs to include processes to ensure that the information in student records follows them through their educational journey. In the absolute worst case and tragic scenario such as a death (as with this youth), these records are crucial to understanding their experiences and addressing potential gaps in delivering the education system.

To Indigenous Services Canada:

3. *To enhance accessibility to Jordan's Principle information and resources by ensuring their availability in (at least) the most widely-spoken Indigenous languages within Canada.*

4. *In consultation with Indigenous peoples, communities and/or governments, to expand accessibility to Jordan's Principle information and resources within remote Indigenous communities by either increasing the availability and scope of the existing 'local service coordinators' or by developing and implementing community "navigators" – directly within the communities – who can assist and support families, caregivers, and Elders in First Nation communities in accessing and navigating the resources, application and approval processes.*

5. *In collaboration with Indigenous people and communities, to simplify the process for accessing Jordan's Principle funding.*

The review of this youth's life indicates that he was in substantial need of supports and services that were not reasonably accessible to him due to his geographic residence, among other factors. While Jordan's Principle funding was being accessed in the immediate months before his death, the inherent gaps and/or barriers to access remain. The LDRT noted that Jordan's Principle is an important child-first approach to ensuring that First Nations children and youth receive services that are equitable to those received by non-First Nations children and are delivered in a timely manner. In 2016, the Canadian Human Rights Tribunal (CHRT) defined Jordan's Principle as:

> A child-first principle which provides that where a government service is available to all other children and a jurisdictional dispute arises between Canada and a province/territory, or between departments in the same government regarding services to a First Nations child, the government department of first contact pays for the service and can seek reimbursement from the other government/department after the child has received the service. It is meant to prevent First Nations children from being denied essential public services or experiencing delays in receiving them[i].

The CHRT found that the underfunding of various services to First Nations children and youth constituted discrimination in violation of the Canadian Human Rights Act and acknowledged First Nations children and youth suffer adverse impacts as a result[ii].

The LDRT also learned that the resources for Jordan's Principle access are only widely available in English and French which presents a challenge for First Nations community members where neither English or French is their first language. Additionally, the resources are usually found online, which may not be accessible for many remote First Nations communities especially as the internet is unreliable. The LDRT was of the opinion that to increase accessibility for Jordan's Principle funding, the resources and applications need to be available in Indigenous languages, and that these First Nation communities can increase their understanding of Jordan's Principle funding and how to apply if education and assistance were available and easily accessible to them within their communities.

Bureaucratic barriers to accessing Jordan's Principle funding may be preventing First Nations children and youth, like this youth, from receiving services that they are entitled to. In addition to language and technology barriers, complex application and appeal processes can create insurmountable barriers for First Nations families living in remote communities. The accessibility barriers need be addressed to ensure that First Nations children and youth are receiving equitable services to help ensure that they are not unnecessarily exposed to dangerous risks, including death.

To the Chief Coroner for Ontario:

6. *To request an opportunity to present the recommendations from the Local Death Review Tables and the overall findings of the Child and Youth Death Review and Analysis (CYDRA) pilot to the Nishnawbe Aski Nation (NAN).*

The LDRT was of the opinion that the Chief Coroner for Ontario should consider requesting an opportunity to present the LDRT recommendations and the overall findings of the CYDRA pilot project to NAN, for example through their remoteness quotient table or Choose Life table. This would provide an opportunity to "report back" to the people and communities that are most impacted by the issues identified at the [redacted] LDRTs and would also provide an opportunity to receive important feedback.

To the Government of Ontario (particularly the Ministry of Education) and the Government of Canada:

7. *To review and analyze existing barriers that may be hindering the education institutions within First Nations communities in Ontario from recruiting and retaining qualified and*

committed education professionals that are necessary for a sustainable and equitable education system.

8. *To develop and implement mechanisms for mitigating barriers experienced by Indigenous education authorities to ensure that First Nations students receive equitable quality and access to education that they would receive if in the provincial publicly funded school systems.*

9. *To review the current allocation of resources to education institutions with consideration to the extensive costs that remote communities often incur for operating their education facilities (e.g. fuel for heating and transportation of personal and other necessities) and the disadvantageous impact this may have on their overall operational success.*

From the available records and information presented by the individuals involved in this youth's care, irrespective of the unavailable OSR, it is understood that school and learning was particularly challenging for him throughout his lifespan. The most recent educational assessment available indicates that this youth was functioning at several grade levels below his age group (i.e. while at the secondary school age level he was functioning at primary and intermediate grade levels). This youth also had to travel to City A to have this assessment done as there was no availability within or near his community.

The LDRT learned that remote Indigenous communities face challenges in recruiting and maintaining qualified education professionals within their education authorities and institutions due to various factors which adversely impacts capacity to thoroughly and promptly identify and address student needs, e.g. special, behavioural and/or mental health needs. They also face disproportionate costs of operating and staffing their education facilities. The education authority of this youth's most recent community, First Nation A, identified these challenges, among others, to have significant impact on their ability to provide education to the children and youth in the community and overall success of their community.

Children and youth living in remote and Indigenous communities should not be disadvantaged in their education because of their geographical location, status, nor any other factor. This youth, and youth like him, deserve unhindered access to quality, equitable and meaningful education including supports they may individually require for success.

To the Government of Ontario and the Government of Canada, in collaboration with Indigenous governments:

10. *To devise a mechanism which facilitates and improves the accessibility, availability and sustainability of mental health services, particularly children's mental health services, within Indigenous communities in remote and northern areas of Ontario, that uses culturally relevant approaches to the specific needs of the First Nations community*

including responses that address the impacts of trauma resulting from historical and ongoing impacts of colonization and racism. Access to qualified mental health professionals and mental health care must be accessible to all Ontarians, directly within or near their home communities, especially for vulnerable populations such as children and youth.

11. *To work in collaboration with Indigenous peoples and communities on the development and implementation of such a mechanism, and on a feasible plan to ensure that these resources and services are culturally relevant and sustainable within their communities.*

The LDRT learned that this youth had suspected mental health and/or developmental issues that exacerbated particularly in the few years preceding his death. These suspected issues were undiagnosed due to various barriers including limited access to mental health care and professionals. Children and youth facing challenges of any kind should not be at a disadvantage due to their community (nor any other factor).

This youth did not have access to professional mental health assessment or support within his community. Extensive efforts were made by his family and community members to attempt to access mental health services in larger communities, towns and cities. While This youth showed several signs of developmental delay and potential mental illness, he did not receive a professional assessment and thus did not have a diagnosis. A mental health/psychological assessment was finally arranged with the Ontario Telemedicine Network (OTN) following this youth's departure from the treatment home however he died five days before the appointment. The LDRT noted that while a child welfare agency was involved with this youth in his community during the exacerbation of his behaviours and signs of mental illness, child welfare workers are not mental health professionals and this youth was likely in most critical need of mental health assessment and care.

The LDRT was of the opinion that children's mental health assessments and services (including qualified professionals) should be available and accessible as needed within Indigenous communities without delay for any person but especially for children and youth.

To Indigenous Child Wellbeing Agency B:

12. *To reflect on and review the organization's interactions with this youth and his family, particularly in the period leading to the youth's death, from a lessons-learned perspective; to explore opportunities for how families in remote communities that are requesting assistance from child welfare (child and family services) and/or that may be in crisis could potentially be better supported in the future.*

The LDRT acknowledged that (although there were no diagnoses) this youth's challenges may have been more likely related to mental health and/or developmental and behavioural issues,

and from the Indigenous child wellbeing agency perspective he was not necessarily in need of "protection". However, given the lack of services and supports available within his First Nation community, the Indigenous child wellbeing agency remained quite involved with the youth and his family, particularly through the exacerbating circumstances leading to his death.

While the Indigenous child wellbeing agency operates staff directly within various First Nation communities, including First Nation A, it is known that there are still barriers and challenges to providing service (e.g. staffing, resources, coordination, etc.). This may contribute to delayed response, assessment and action to various circumstances and/or events. There are some interactions in the history of this youth's case that may be an example of this, e.g. after this youth threatened to burn down his family home, the Indigenous child wellbeing agency was unable to follow-up and completely address the circumstances with the family until a month later; and while the family expressed an inability to safely care for this youth and requested he be brought 'into care', the Indigenous child wellbeing agency did not have any available placements for him in his community which led to him residing in the Safe House.

Given that the Indigenous child wellbeing agency was the most closely involved with the family, and that the family repeatedly requested further assistance including for this youth to be put 'in care', it could be beneficial for the Indigenous child wellbeing agency to reflect on their involvement with this youth and family to identify any 'lessons learned' that may assist in the future. This may include collaborating with multisectoral counterparts regarding enhancing coordination of services and wraparound approaches.

To the Office of the Chief Coroner:

13. *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 youth throughout his lifespan were involved in this review.

Not all records relating to this youth and his interactions were available, used or identified for this review. Specifically, This youth's complete Ontario Student Record (OSR) was not available for this review as it could not be found by his previous education institutions. Although some insights into this youth's education may have been identifiable through other service system records, the entirety of his educational experiences were not.

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 youth's life and/or his interactions or involvements were included in this review and report.

[i] First Nations Child and Family Caring Society of Canada et al. v. Canada (for the Minister of Indian and Northern Affairs Canada), 2016 CHRT 2 at para 351.
[ii] First Nations Child and Family Caring Society of Canada et al. v. Canada (for the Minister of Indian and Northern Affairs Canada), 2016 CHRT 2 at paras 458-467