Report of the **Paediatric Death Review Committee** and **Deaths Under Five Committee**

Office of the Chief Coroner
Province of Ontario
September 2012

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Message from the Chair

It is my pleasure to present the Report of the Paediatric Death Review Committee (PDRC) and the Deaths Under Five Committee (DU5C). This report is my fifth and final report, and reflects the activity of the Committees in 2011. Beginning in January 2011, Dr. Dirk Huyer became the Chair of the DU5C; as of January 2012, he also became the Chair of the PDRC. Please join me in welcoming him in his new role of leading both Committees.

This report has been redesigned and fashioned into three components; a section for the general public on safety issues; a section for healthcare providers related to patient safety; and finally, the child welfare component of the report. The format is shortened and was redesigned this year. We hope you enjoy the new look.

The past year was an eventful year. The Drowning Report was released in June 2011 and detailed the Office of the Chief Coroner's concerns regarding the safety of children under the age of five near water. Tragically, 13 of 89 deaths reported from May 1st to September 30th, 2010 occurred in children less than five years of age. Recommendations were directed to the Ministry of Education to make water safety knowledge a core component of the education curriculum and asking that school boards develop advanced programs for children so that they are able to swim before graduating from elementary school.

In addition, the Pikangikum Youth Suicide Report was released in September 2011. It reviewed the deaths of 16 First Nations youth over a three year period. These youth resided in the Pikangikum First Nation, a remote fly-in community of approximately 2,500 residents in the North West of Ontario. Their community does not have running water and few residents have a sewage system. The school exists as a series of portables and truancy of the children is a major concern. Poverty and substance abuse, including gasoline sniffing were prevalent in the lives of these unfortunate children. The report provides 100 recommendations addressing the issue of suicides of youth in Ontario's First Nations communities. This edition of the annual report presents a submission from the Ontario Association of Children's Aid Societies (OACAS) on the state of First Nations children and youth involved with child welfare.

The Provincial Advocate for Children and Youth (PACY) held two days of hearings at the Ontario Legislature in 2011. The Youth Leaving Care Hearings took place November 18th and 25th. The final report was released in May 2012 and has a principle key recommendation, followed by six recommendations for immediate change. Some of the PDRC's independent recommendations to the Ministry of Children and Youth Services in 2011 mirror those made by the Youth Leaving Care Hearings. The Provincial Advocate has provided a brief review of his work around this issue which you will find in this report. This year, the Office of the Chief Coroner (OCC) completed a Memorandum of Understanding for the Disclosure of redacted PDRC reports to the Office of the Provincial Advocate for Children and Youth, upon written request.

The Office of the Chief Coroner conducted four inquests involving children in 2011. The Anderson Inquest was a discretionary inquest where a tragic fire resulted in the death of a mother and two of her children. The family had been involved with the child welfare system. The Anzovino Inquest was a discretionary inquest which examined the death of an 18-year-old due to a motor vehicle collision in the Niagara

Message from the Chair

Region. The Ilunga Inquest was a discretionary inquest into the death of an eight-year-old girl who drowned in a public pool. In addition, there was a mandatory inquest conducted into the death of a youth (name withheld to comply with the privacy requirements of the Youth Criminal Justice Act) who died while in custody.

On May 31st 2012, the Chief Coroner announced an inquest examining the deaths of seven First Nations youth in Thunder Bay. These youths had left their homes in First Nations communities to come to Thunder Bay for the purposes of attaining a high school education. The seven deaths occurred over a period of approximately ten years.

On a positive note, *Katz et al* reviewed the issue of suicide and suicide attempts in children and adolescents in the child welfare system in Manitoba. The conclusion of the study stated, *"Although children and adolescents in care are at greater risk of serious psychiatric morbidity and mortality than the general population, it appears that the rates of these outcomes are highest before entry into care and then decrease."*[1] This important study can assist in providing guidance to Children's Aid Societies as they forge policies around the management of the most vulnerable sector in our society: children suffering with mental illness in need of services from a Children's Aid Society.

I would like to express my sincerest thanks to members of the Deaths Under Five Committee and the Paediatric Death Review Committee for their dedication and devotion to the difficult work that they assist the Office of the Chief Coroner in completing.

On Tuesday May 29th, 2012, I attended a Deaths Under Five Committee meeting. Extraordinarily complex cases were discussed. Sitting at the table were four forensic pathologists, two coroners, paediatric child maltreatment experts, several homicide officers from different services, a crown attorney, a child welfare consultant, a representative from Health Canada and a variety of learners from different disciplines. In one compelling case of a paediatric head injury death, the discussion went on for considerable length of time with the Chair ensuring that a wide variety of thoughts, arguments and opinions were considered. Ultimately, consensus was reached.

In the post-Goudge era, I took satisfaction from the discipline utilized to obtain the best answers to difficult questions, and found myself asking if the degree of questioning and investigation done in Ontario was being replicated anywhere else in the world. Ontarians can take great comfort in our current processes of reviewing the deaths of children investigated by the Office of the Chief Coroner.

Thank you for the privilege of having served you, the public, and the children of Ontario as the Chair for the past four years.

Your Grateful Servant,

Dr. Bert Lauwers
Past Chair, Paediatric Death
Review Committee 2007-2011
Deputy Chief Coroner-Inquests

[1] Katz, LY et al, *Suicide and suicide attempts in children and adolescents in the child welfare system,* CMAJ, November 22, 2011, 183(17), pg. 1981.

Part 1: Public Safety Message to Prevent Deaths of Children

An Analysis of Paediatric Deaths in Ontario (2009)

Themes in paediatric death remain fairly constant over time. Many childhood injuries and deaths are preventable. The Office of the Chief Coroner (OCC) presents the following section to assist the public in understanding, and hopefully preventing, unnecessary deaths of our children.

The following data come from an analysis of completed coroner's investigations which have undergone full quality assurance review and are closed. 2009 is the most recent year of completed cases; this analysis includes data across the paediatric age spectrum and is representative of the annual trends noted in Ontario. Some recommendations are offered directed toward preventative measures for deaths of children and youth by accident and suicide and for deaths of infants in unsafe sleep circumstances.

Paediatric Deaths Investigated by a Coroner in 2009

In Ontario, the manner of death (or "by what means" a person comes to their death) is classified as one of the following: natural, accident, suicide, homicide or undetermined. In 2009, there were 472 paediatric deaths (ages 0-18 years inclusive) investigated by coroners; under 12 months (146); 1-4yrs (58); 5-9yrs (37); 10-15yrs (88); 16-18yrs (143).

As shown in Figure 1 (next page), the manner of death for these cases was: natural (175/37%), accident (150/32%), undetermined (74/16%), suicide (46/9%), and homicide (27/6%).

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Patterns across Age Groups based on Manner of Death

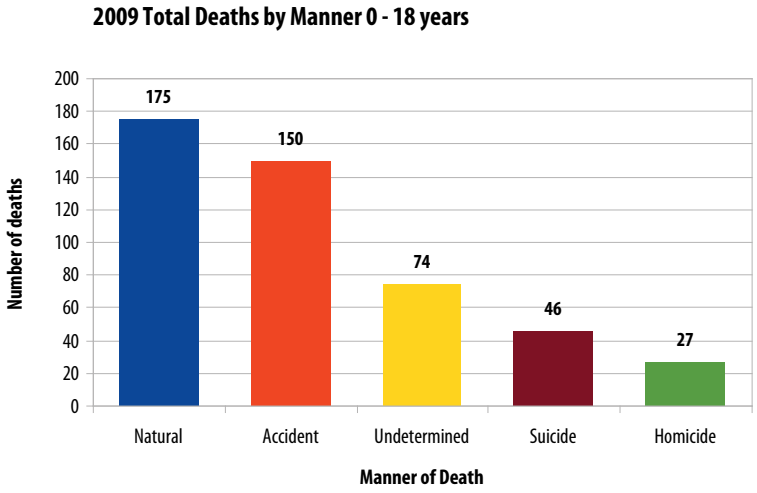

Figure 1: All paediatric deaths in 2009 distributed by manner of death, all age groups combined.

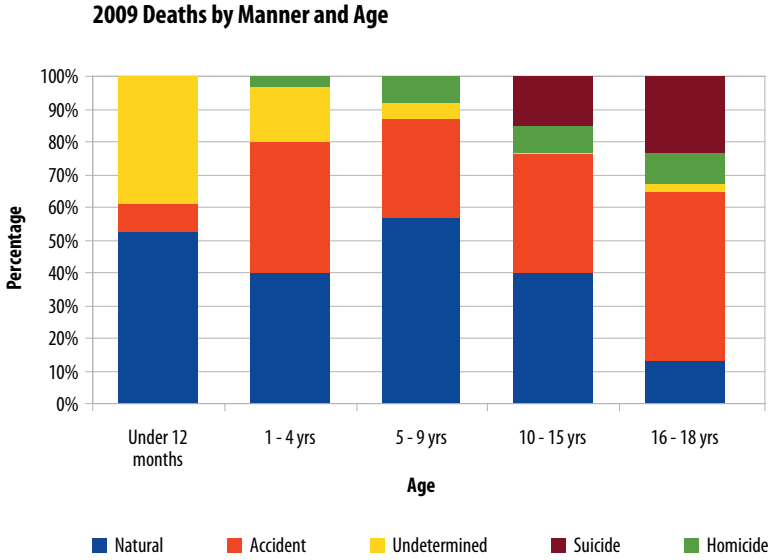

Figure 2: Distribution of paediatric deaths in 2009 by manner of death. Generally, natural deaths become less common as children age while deaths by accident show the opposite pattern and become more common. Suicide increases with age between 10 and 18 years of age. Homicides slightly increase with age as well. Undetermined deaths are most common in infants under 12 months of age and are largely represented by deaths of children in unsafe sleep environments.

Part 1: Public Safety Message to Prevent Deaths of Children

Characteristics of Paediatric Deaths Based on Age

Deaths under 12 months of age

146 deaths

Gender: 53% Male and 46% Female. There was no significant difference between males and females.

Age: The most common age of death was between 1-6 months and the least common was between one hour and one day.

Manner of Death: For the majority of the cases involving infants less than 12 months of age, the manner of death was natural (54%), followed by undetermined (40%). Of the undetermined deaths, 67% involved an unsafe sleeping environment (USE). From the cases classified as undetermined with USE, 54% involved sharing a sleep surface (bed-sharing) with adults (parents) and /or older siblings.

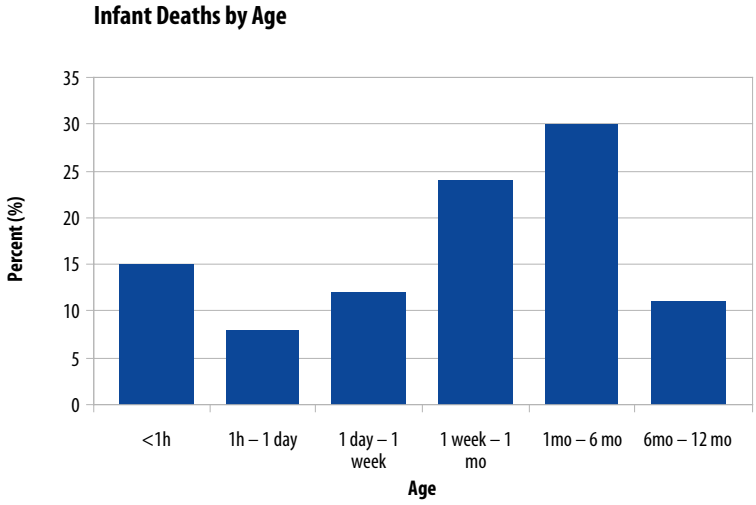

Figure 3: Distribution of infant deaths by age (2009). The peak falls on the age group between 1-6 months.

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Characteristics of Paediatric Deaths Based on Age

Deaths between 1-4 years of age

58 deaths

Gender: Deaths were far more common among boys (72%) than girls (28%).

Age: The number of deaths in this age category decreased as the children age. Most deaths in this age group occur in children 1-2 years of age.

Manner of Death: Deaths for children in this age group were classified as natural (40%); accident (40%); undetermined (17%); homicide (3%).

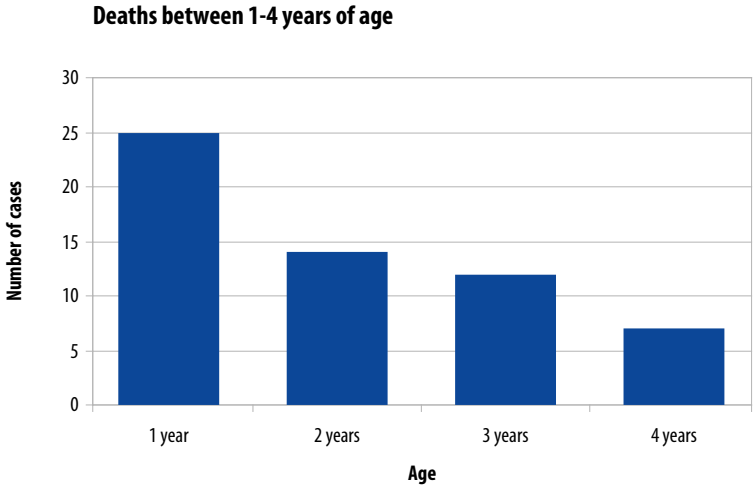

Figure 4: Distribution of deaths by age for each year in the 1-4 year age group (2009).

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Characteristics of Paediatric Deaths Based on Age

Deaths between 5-9 years of age

37 deaths

Gender: There were almost an equal number of boys (51%) and girls (49%) who died in this age category.

Age: 5 – 9 years of age; for no known reason, the deaths peaked at age 7.

Manner of Death: Deaths of children in this age group were classified as: natural (57%); accident (30%); homicide (8%); undetermined (5%).

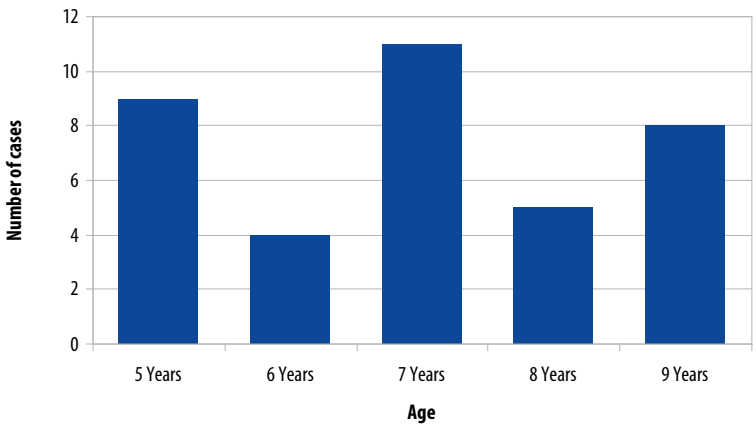

Figure 5: Distribution of deaths by age for each year in the 5-9 year age group (2009).

Unsafe

vs.

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Characteristics of Paediatric Deaths Based on Age

Deaths between 10-15 years old

88 deaths

Gender: There were significantly more boys (63%) than girls (37%) who died in this age category.

Age: 10 – 15 years. 75% of the children in this age group were over 13 years old.

Manner of Death: Deaths of children in this age category were classified as: natural (40%); accident (36%); suicide (15%); homicide (8%); undetermined (1%).

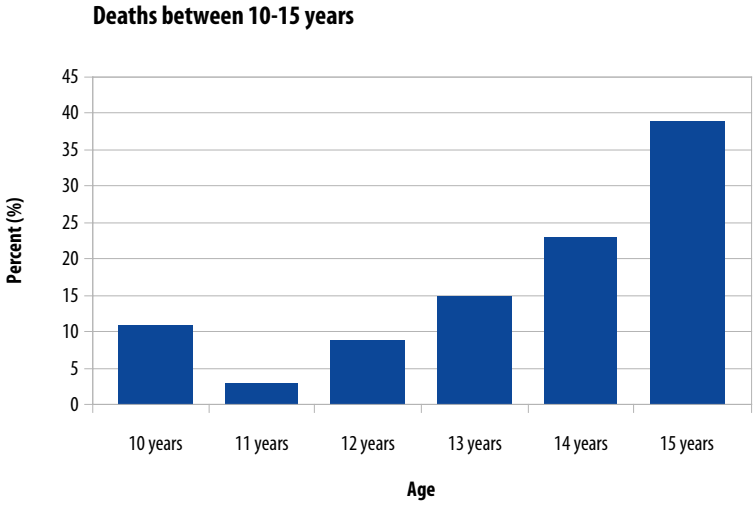

Figure 6: Distribution of deaths by age for each year in the age group 10-15 (2009).

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Characteristics of Paediatric Deaths Based on Age

Deaths between 16-18 years of age

143 deaths

Gender: A significantly greater percentage of boys (74%) than girls (26%) died in this age category.

Age: 16-18 years of age (up to the 19th birthday). The total number of deaths in this age category increased with each year of age.

Manner of Death: 52% of the deaths in this age group were classified as accident; natural (13%); homicide (10%); suicide (23%) and undetermined (2%). Clearly, older adolescents are at a significantly higher risk of accident, suicide and homicide than any other age group.

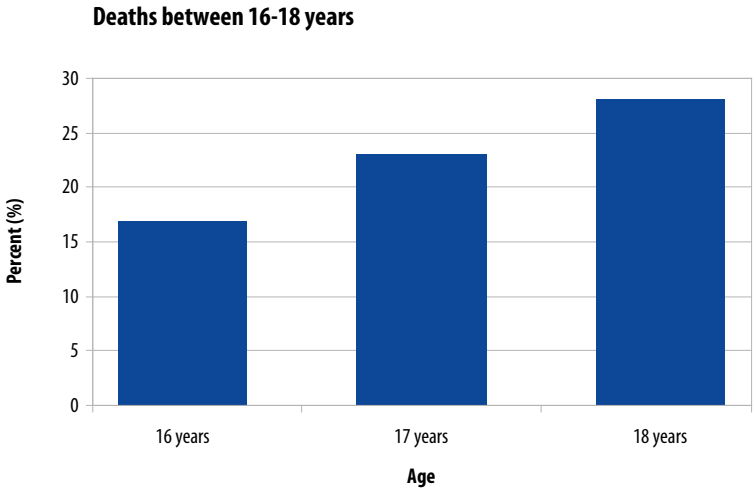

Figure 7: Distribution of deaths by age for each year in the age group 16-18 inclusive (2009).

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Deaths by Accident

After natural deaths, accident (150) is the most frequent classification and the more likely preventable type of death among children. Motor vehicle collisions (MVC) are the most common of accidental deaths among all children (48% of cases), whereas deaths due to a fall are the least common (4%).

For deaths due to fire, in most cases the smoke alarms were present in the house, but were not operational.

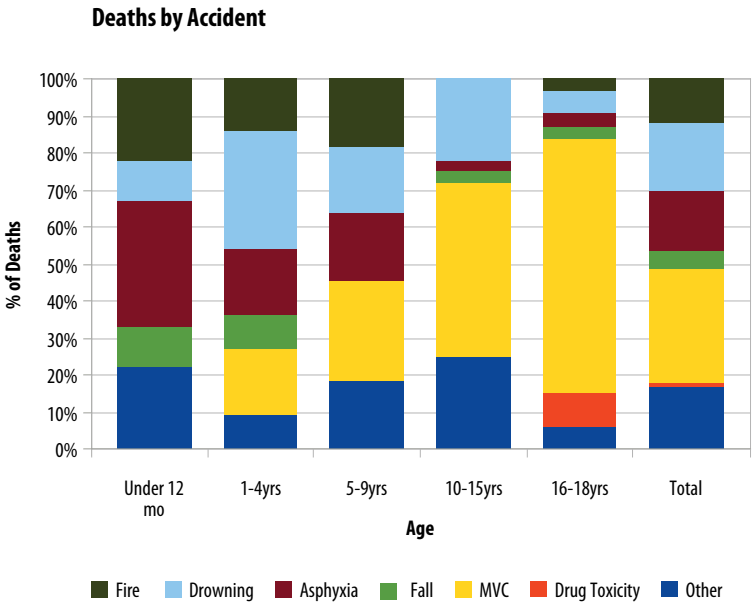

Figure 8: All deaths by accident that occurred in 2009 distributed by age groups.

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Public Safety Recommendations - Prevention Strategies

1. Reducing Accidental Deaths in Children

Accidents accounted for 32% of all deaths of children 0-18 years of age in 2009. While the types of accidental deaths vary across the age span, motor vehicle collisions are the most common, followed by drowning and fire deaths. Based on child death reviews and in consultation with experts who work in injury and death prevention, we offer some strategies to reduce the risk of future injury and deaths.

Prevention strategy #1-Reducing deaths in motor vehicle collisions:

- Always wear your seatbelt and always ensure children are in a proper car restraint system.
- Obey the rules of the road and speed limits.
- Teach children and teenagers the dangers of driving with anyone who is under the influence of drugs and/or alcohol.
- People of all ages should wear an appropriate certified helmet when riding a bicycle, skateboarding, in-line skating and scooter riding; the law requires everyone under 18 to wear a helmet when cycling.
- Visit the following links for more information:

http://www.mto.gov.on.ca/english/safety/carseat/choose.shtml
http://www.mto.gov.on.ca/english/dandv/driver/gradu/index.shtml

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Prevention Strategy #2-Reducing deaths of children in fire fatalities

- Install smoke alarms and carbon monoxide detectors.
- Check and replace batteries regularly so that they are always functional.
- Replace smoke alarms if they are more than ten years old.
- Educate children on what should be done when the fire alarm sounds.
- Practice an escape plan.
- Teach children not to play with matches, lighters and other ignition sources; store these items out of reach of children.
- Do not leave small children unattended in the house.
- Visit the following link for further information on fire safety or contact your local fire department:

  http://www.ontario.ca/firemarshall
  http://www.safetyfirstint.com

Reprinted with permission from:
www.newchild safety.com

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Prevention Strategy #3-Reducing deaths of children due to drowning

- Always supervise young children around water, including bath tubs.
- Ensure children always wear a life jacket around pools and other bodies of water.
- Install safety mechanisms to prevent children from entering pools, ponds and hot tubs.
- Visit the following links for more information:

  http://www.safekidscanada.ca
  http://www.lifesavingsociety.com

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2. Reducing Deaths by Suicide

Suicide was responsible for 15% of the deaths of 10-15 year olds and 23% of the deaths of 16-18 year olds in 2009, a concerning fact.

- Know the warning signs and risks associated with suicide.
- Try to be open and supportive of children and youth.
- Teach children and adolescents to tell someone if they know of anyone who may be talking about harming themselves.
- You can get more information on warning signs of suicide and what to do if you visit the following links:

http://www.suicideprevention.ca/about-suicide/suicide-first-aid-guidelines/
http://www.cmha.ca/mental_health/preventing-suicide/
http://suicideinfo.ca/

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3. Reducing Deaths Associated with Unsafe Sleep Environments

A safe sleeping environment is highly recommended as it greatly reduces the risk of sudden unexpected death in infancy. 67% of all undetermined infant deaths in 2009 involved an unsafe sleeping environment, including the sharing of a sleep surface.

- Infants should sleep on their back for every sleep.
- Infants should sleep in an approved crib, bassinet or cradle with a firm mattress (approved by Health Canada).
- Never place a baby to sleep on an adult mattress, sofa, pillow or any other soft material.
- Bed sharing (sharing a sleep surface) should be replaced by room sharing (sleeping in the same room).
- Keep the crib empty of unnecessary items such as extra blankets, toys, pillows, etc.
- Keep the room temperature within the approved norms (16-20°C) to prevent overheating and do not overdress an infant.
- Do not leave infants sleeping on any surface not designed for safe sleep such as car seats, swings, strollers.
- For more information choose the following links:

Unsafe

vs.

Safe

Caring for kids
http://www.caringforkids.cps.ca/handouts/safe_sleep_for_babies

Public Health Agency of Canada
http://www.publichealth.gc.ca/safesleep

Health Canada
http://www.hc-sc.gc.ca/cps-spc/index-eng.php

Canadian Foundation for the Study of Infant Deaths
http://www.sidscanada.org

Canadian Paediatric Society
http://www.cps.ca

Paediatric Inquests

Anderson Inquest

Ms. Diane Anderson, aged 35, Tayjah Simpson, aged nine, and Jahziah Whittaker aged three, died of inhalation of smoke and fire gases on December 22, 2007.

The Chief Coroner ordered a discretionary inquest into the deaths.

Ms. Anderson was a 35 year-old mother of five children, who died in a house fire at their Toronto Community Town House on December 22, 2007. Her nine year-old and three year-old child also died in that fire. Ms. Anderson had been a resident of the Grandravine Toronto Community Housing Corporation Complex for approximately 12 years.

Tragically, Ms. Anderson was engaged to be married when her fiancé was shot to death. She mourned his loss which had a significant effect on her mental health. She began to drink excessively and use illicit drugs. Ms. Anderson's family had been referred to the Children's Aid Society on five occasions prior to the fatal fire. On December 21, 2007, Ms. Anderson had been drinking alcohol during the day, and fell asleep on a sofa chair. In the early hours of December 22nd, it is believed that her two younger children started a fire on a futon using her lighter.

One of the children ran upstairs to wake the eldest child who attempted to get the children out of the house, but was forced out herself due to flames and smoke. The fire alarms did not activate, and subsequent fire investigation revealed that the alarms were not connected to electrical power.

The Jury made a total of 32 recommendations. Key recommendations included:

Ministry of Community Safety and Correctional Services (MCSCS)

It is recommended that the Fire Code should be amended to require all residential landlords/owners to test smoke alarms annually and to maintain records of such inspections for two years.

Ministry of Children and Youth Services (MCYS)

It is recommended to the Ministry of Children and Youth Services that all Provincial Children's Aid Societies work with the MCYS and the Ontario Fire Marshal's Office to develop a protocol to support fire safety education. This education will include the importance of working smoke alarms and developing escape plans specific to their household situation. This initiative would require the case worker with access to the home to document fire alarm testing in the Safety Assessment Tool and distribute fire safety literature to the family.

Ministry of Municipal Affairs and Housing

It is recommended that the Ministry of Municipal Affairs and Housing amend the Ontario Building Code to require automatic fire sprinklers in all newly constructed residential buildings regardless of size or height.

Paediatric Inquests

Anzovino Inquest

Reilly Kennedy Anzovino died on December 27, 2009 at Welland County General Hospital due to Blunt Force Trauma due to a motor vehicle collision.

The Chief Coroner ordered a discretionary inquest into the death.

source: www.wikipedia.org

On December 26, 2009 Ms. Anzovino was travelling in a vehicle driven by a friend when it spun out of control and struck another car. The road was covered by "black ice." Although initially unconscious, Ms. Anzovino regained consciousness before losing her pulse on the way to the hospital. There had been a delay in her ambulance transport from the scene to the Welland Hospital.

Concern had been raised in the community because of the recent conversion of the local emergency departments to urgent care centres. There was a perception that the increase in transport time to the Welland Hospital may have contributed to her death.

The Jury made a total of 32 recommendations. Key recommendations included:

Niagara Health System (NHS)

We encourage the Niagara Health System to conduct a study in conjunction with the LHIN [Local Health Integration Network] and in consultation with HHSC [Hamilton Health Sciences Centre], as to the feasibility of concentrating resources and trauma patients at one of the hospital sites of the NHS.

Ontario Emergency Medical Services (EMS)

We recommend that all EMS operators ensure that all paramedics understand that "Load and Go" is an expected standard to be met unless exceptional circumstances exist. In any Canadian Triage and Acuity Scale (CTAS) 1 or 2 cases where this standard is not met, appropriate documentation and incident report be filled out and provided to their Base Hospital for its consideration and ensuing review.

Ministry of Health and Long-Term Care (MOHLTC) and Base Hospitals

In addition to the "Load and Go" content contained in the ITLS [International Trauma Life Support] course, we encourage the MOHLTC to review the training and/or standards provided to paramedics concerning the "Load and Go Patient Standard" set out in the Basic Life Support Patient Care Standards. The review should ensure that the training and standards rely on evidence-based medicine. Any required medical interventions should be attempted en route to hospital, and should not delay the departure from the scene.

Paediatric Inquests

Ilunga Inquest

Edine Ilunga died at Children's Hospital of Eastern Ontario, Ottawa on October 19, 2008. The cause of death was drowning and the manner of death accident.

The Chief Coroner ordered a discretionary inquest into the death.

Edine Ilunga had attended a birthday party hosted at the Kanata Leisure Centre and Wave Pool on the evening of October 18, 2008. Following some snacks and gift opening, the attendees entered the pool where a public wave swim was in progress. Some of the parents of the party attendees were in the pool. The host parents were not in the pool. Edine was unaccompanied and had been seen floating on a mat. Approximately 70-80 bathers were in the pool. At about 1945 hours, lifeguards were alerted that a swimmer had vomited in the pool. The wave generator was not active at the time, but had been shortly before. Edine was found face down in the water in the deep end of the pool. She was recovered by lifeguards and cardiopulmonary resuscitation (CPR) was performed on the pool deck. An automated external defibrillator was applied, but not activated. Paramedics responded and continued resuscitation with resumption of a pulse. Edine was transported to the Children's Hospital of Eastern Ontario where she was found to have hypoxic-ischemic brain injury. Ventilator support was withdrawn and she died at 0658 hours on October 19, 2008. An autopsy confirmed that the cause of death was drowning.

The Jury made a total of 15 recommendations. Key recommendations included:

Ministry of Health and Long-Term Care (MOHLTC)

The Health Protection and Promotion Act, Regulation 565 should be amended to include a provincial swimming pool bather admission and bather tracking standard prior to the end of 2011. This standard should incorporate the elements set out in Appendix 1 (below) and there should be a requirement that the standard should be posted, at a minimum, in the pool reception area and on the pool deck. Training should be required of all applicable staff in the application of this standard and the standard should be communicated to the public.

Paediatric Inquests

Appendix 1:

1. **Admission and tracking standard for recreational non-instructional swimming**

   - Children 10 years and under, who are non-swimmers must be accompanied by a parent or guardian who is at least 16 years of age and responsible for their direct supervision. The ratio of non-swimmers to parent or guardian may be a maximum of 4 bathers to one parent or guardian (4:1). The ratio of non-swimmers to parent or guardian may be increased to a maximum of 8 bathers to one parent or guardian (8:1) if lifejackets are worn by all non-swimmers in their charge.
   - Children aged 8 - 10 who are swimmers (able to demonstrate comfort in the water and pass the facility swim test) may be admitted to the swimming pool unaccompanied.
   - Children 7 years and under may not be admitted to the swimming pool unless they are accompanied by a parent or guardian who is at least 16 years of age and who is responsible for their direct supervision, with a maximum of two children for each parent or guardian.
   - "Direct supervision" is defined as being able to render immediate assistance "within arm's reach."
   - Owner / operators must develop a procedure by which the application of the admission standard can be tracked and identified on the bathers to which the standard applies.

2. **Local Boards of Health should communicate any amendments to Regulation 565 to owner/ operators; and**

3. **Provide for a "short form" wording in order to allow the amended Regulation 565 to be enforced more easily.**

4. **Consider the establishment of a rating system for public swimming pools based on compliance with safety regulations, best practices and guidelines. The ratings should be made available to the public.**

Paediatric Inquests

Youth Inquest

A youth, aged 17, died at Oakville Trafalgar Memorial Hospital (now Halton Healthcare Services) in Oakville Ontario on May 13, 2008. The cause of death was hanging by ligature (shoelaces) and the manner of death was suicide.

The name of the youth whose death was examined during this inquest is withheld to comply with the privacy requirements of the *Youth Criminal Justice Act.*

Pursuant to Section 10 (4.2) of the Coroner's Act, the Chief Coroner ordered a mandatory inquest into the death as the youth was in custody at the time he died.

The youth assaulted his sister in January 2008. Three days after the assault, the youth was apprehended by police and charged with assault and breach of probation. He had previously been convicted of robbing a convenience store with a knife. In a second incident, he had been convicted of assaulting a student when he attempted to cut a student's hair with scissors.

By January 2008, his behaviour had deteriorated in a number of ways; he was truant from school, missing his curfew, breaking rules, making inappropriate sexual comments, downloading a large amount of pornography, being disrespectful to his mother, and abusing substances which included daily marijuana use and binge use of Ecstasy. One week prior to his January arrest, he reported to a psychologist that he had been picked to save the planet and universe from certain individuals.

At a court date on January 25, 2008, he pled guilty to all charges and consented to his detention. An assessment was ordered by the judge to assist with sentencing. The assessment concluded that the youth had significant mental health, relationship and substance abuse issues. The youth was sent to Syl Apps Youth Centre on April 14, 2008 with a Warrant of Committal and an order for a Not Criminally Responsible (NCR) assessment.

A limited amount of information was shared upon transfer from the youth detention centre to Syl Apps Youth Centre and this resulted in a lack of knowledge of his progressive mental health issues with the receiving facility. Essentially, his mental health assessment was re-initiated at the time of admission to Syl Apps Youth Centre. His condition deteriorated with increasingly unusual behaviour. On May 13, 2008, the youth was found suspended from a perforated metal protective cage by two shoe laces in his room.

The Jury made a total of 71 recommendations. Key recommendations included:

Ministry of Children and Youth Services (MCYS)

In consultation with the Ministry of the Attorney General (MAG) and other justice system participants, consider legislative change or policy revision that would require, unless prohibited by Court Order, mental health assessment reports are provided to:

a. *Assessors doing a subsequent mental health assessment of the same youth, and*
b. *Probation Officers who have direct involvement with the youth*

Provide increased clinical resources for youth mental health, for those in conflict with the law.

Paediatric Inquests

Youth Inquest

Ministry of the Attorney General (MAG)

Develop tools, in the nature of quick references, for Crown Attorneys regarding responding to youth with mental health issues, including what type of assessments are available and how these assessments are to be arranged.

Ministry of Children and Youth Services and the Ministry of the Attorney General

Ensure that there is a contact person in each youth court and, as a safeguard, a designated contact person for each MCYS Youth Justice Service Division Regional Office, to provide assistance with system navigation and guidance on local contacts, resources and processes to access mental health supports and services for youth in the Justice System including providing guidance on the following questions. The contact person in each youth court would be responsible for developing and maintaining this information for him/herself and their regional office.

a. *What mental health services are available in the community for adolescents and their families?*
b. *What residential or inpatient services are available?*
c. *What is secure treatment and how does the application process work?*
d. *What is emergency secure treatment and how does it work?*
e. *Are there any Assessment, Stabilization and Treatment Units for adolescents that would be appropriate?*
f. *What is a community treatment order and is it a possible option?*
g. *To what extent does the Ministry fund any open detention/open custody beds in children's mental health centres?*
h. *What are the different types of assessments and how are they arranged and funded?*

Ministry of Children and Youth Services and the Ministry of the Attorney General and the Criminal Lawyers Association (CLA)

Mandatory multidisciplinary education relating to mental health and youth criminal justice should be held and should include psychiatrists, psychologists, legal aid, defense, Crowns and other professionals who wish to practice in this field. The purpose of this education is to ensure that all participants have an increased awareness of the roles and responsibilities of each other and to promote understanding and communication among the participants.

To Ministry of Children and Youth Services and Ministry of Health and Long-Term Care (MOHLTC)

Increasingly consult and work cooperatively to ensure that youth in the justice system, including those detained in custody, have access to mental health services that address their needs. This should include collaboration between community based and hospital based mental health facilities and youth justice participants. In particular, to assist MOHLTC in participating in the treatment of these young people, a protocol should be developed to facilitate admission, if necessary, of youth in the justice system with serious mental health problems, to beds in psychiatric facilities under mental health legislation with specialized support from the youth justice system.

Part 2: Paediatric Death Review Committee and the Medical Community

Introduction

The PDRC of the Office of the Chief Coroner meets eight to ten times per year. It is a multidisciplinary committee and attendees typically include a paediatric pathologist, two senior coroners, senior homicide detectives, several child welfare consultants, two paediatric intensivists, three community paediatricians, a neonatalogist, and a representative from the Ontario Association of Children's Aid Societies. The PDRC has two components, medical and child welfare. The following information pertains to cases reviewed in 2011 where medical issues were identified. 2011 PDRC reviews with child welfare involvement are detailed in Part 3, beginning on page 52.

In the medical component of the PDRC, the reviewers comprehensively review the medical care provided to infants, children and youth where there have been challenges (see case reviews included on pages 29-34). Typically, the medical PDRC members review approximately 25 cases where a question about some element of the medical care exists.

Part 2: Paediatric Death Review Committee and the Medical Community

Concerns raised by families often related to issues with communication where the family had attempted to discuss concerns about potential adverse events and near misses during the care their child received during the child's terminal illness. Adverse events are unintended injuries or complications that are caused by health care management, rather than by the patient's underlying disease, and that lead to death or disability, at the time of discharge or prolonged hospital stays.[2] The body of medical literature relating to adverse events continues to grow. A recent publication by Daniels et al examined the identification of paediatric adverse events and near misses reported by families. An interpretation of the study was that:

"The introduction of a family-based system for reporting adverse events involving paediatric inpatients, administered at the time of discharge, did not change rates of reporting adverse and near misses by healthcare providers. Most reports submitted by families were not duplicated in the reporting system for healthcare providers, which suggest that families and staff members view safety-related events differently. However, almost half of the family reports represented legitimate patient safety concerns. Families appeared capable of providing valuable information for improving the safety of paediatric inpatients.[3]"

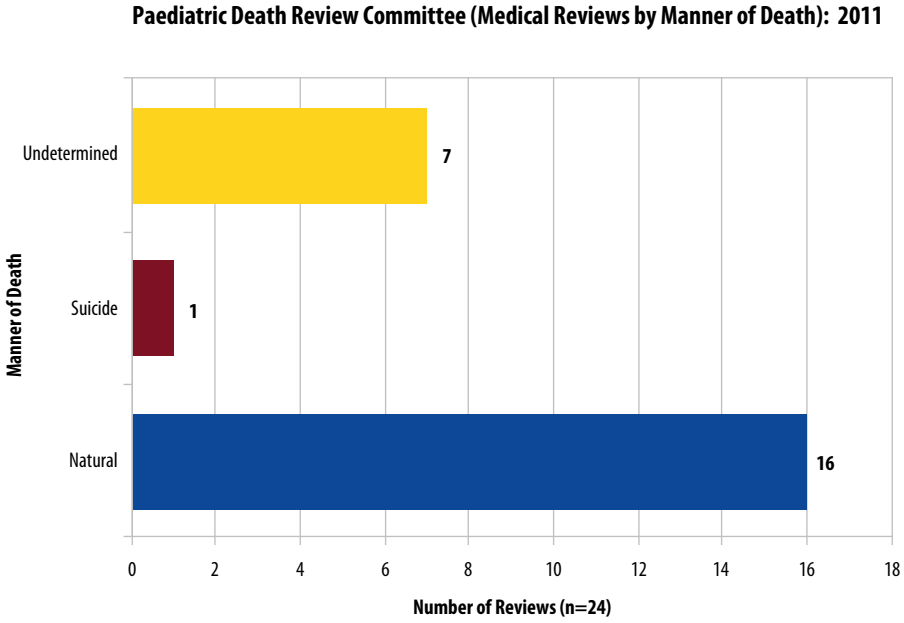
[2] Baker, R et al, *The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada, CMAJ May 25, 2004 vol. 170 no. 11 doi:* 10.1503/cmaj.1040498.

[3] Daniels, JP et al, *Identification by families of pediatric adverse events and near misses overlooked by health care providers,* CMAJ January 10, 2012, 184(1).

Part 2: Paediatric Death Review Committee and the Medical Community

Medical PDRC Reviews Based on Manner of Death

2011 Case Reviews



- In 2011, the medical experts of the Paediatric Death Review Committee (PDRC) reviewed 24 deaths.
- Of the 24 deaths reviewed by the PDRC, 13 (54%) were male; 11 (46%) were female.
- The majority of deaths, 16 (67%) were classified as natural.
- 7 (29%) of the deaths were classified as undetermined; and 1 (1%) was a suicide.

2004 - 2011 Case Reviews

Year	Natural	Accident	Homicide	Suicide	Undetermined	TOTAL
2004	18	3	1	2	3	**27**
2005	20	1	0	0	0	**21**
2006	20	0	0	0	3	**23**
2007	17	0	0	1	0	**18**
2008	30	1	1	0	8	**40**
2009	19	2	0	0	7	**28**
2010	19	2	2	0	5	**28**
2011	16	0	0	1	7	**24**

Part 2: Paediatric Death Review Committee and the Medical Community

Vomiting: What Does it Mean in Children?

Desmond Bohn MB FRCPC

"He's been vomiting doctor." Dr. Jim looked across his desk at the sickly, listless looking infant sitting in his mother's lap. There was an hour and a half left in his shift in the emergency department (ED). It had been a really busy day. There was a bit of an epidemic of some sort of viral illness in the community and the ED had been flooded with patients. Even before he responded to the mother he was thinking to himself "another case of gastro." Well why wouldn't he – common things being common? However, he was about to make a major error because he didn't ask her whether the child had diarrhoea. If he had, she would have told him "no." He wouldn't have written an order for oral rehydration fluid which didn't help this child who, in fact had meningitis and was vomiting because of raised intracranial pressure.

So how do we avoid this sort of error? Firstly, we must recognize that vomiting is a non specific symptom with many causes, most of which are unrelated to the gastrointestinal (GI) tract, particularly in children. Next, by taking a careful history which, if completed in this case, would have ruled out gastroenteritis. Following this, questioning the mother about how many times the child had vomited and the characteristics of the vomitus (? bilious) which might point towards a gastrointestinal tract (GI) obstruction. Then, questioning the caregiver about other symptoms including, appetite, physical activity, weight loss, fever etc. A careful physical examination should include all vital signs and an abdominal examination.

Common Causes of Vomiting in Children	Comments
Gastrointestinal: • Gastroenteritis • Peritonitis • Volvulus • Intersussception • Bowel infarction • Incarcerated hernia • Pyloric stenosis	Gastroenteritis should be a diagnosis of exclusion. Invariably associated with diarrhoea. Abdominal rigidity in peritonitis. Bilious vomiting characteristic of bowel obstruction. Abdominal distention and dilated small bowel loops seen on x-ray. Most GI tract abnormalities can be diagnosed by ultrasound exam.
Central Nervous System: • Meningitis/encephalitis • Hydrocephalus/blocked ventriculoperitoneal (V-P) shunt • Brain tumours • Head injury	History of vomiting, lethargy and headache are common signs of raised intracranial pressure (ICP). Bradycardia and hypertension are late signs. Vomiting in a child with a V-P shunt is strong indication of shunt blockage.
Miscellaneous causes: • Diabetes mellitus • Toxic ingestions • Cardiogenic shock (myocarditis, cardiomyopathy) • Urinary tract infection	Weight loss, polydipsia, polyuria in diabetes mellitus. Vomiting is among the commonest symptoms with presentation of low cardiac output and shock.

The table above outlines the more common causes of vomiting in children. As can be seen, many of the causes are unrelated to diseases of the gastrointestinal tract. Indeed, many of the causes are entirely remote from it. Take for example cardiogenic shock. While acute myocarditis is a rare entity, the commonest symptom in children is vomiting, the explanation for which is either centrally mediated or due to low output producing gut ischaemia. The differential can be narrowed down by careful history collection and physical examination.

Part 2: Paediatric Death Review Committee and the Medical Community

KEY MESSAGE:

Not All Vomiting in Children is Gastroenteritis!

The physiological mechanisms that result in vomiting are complex. We do know that there is bilateral vomiting or emetic centres in the medulla in the brain which receive input from chemoreceptors in the fourth ventricle as well as afferents from the GI tract via the vagus nerve. There are also afferent signals from the peritoneum, bile ducts, heart and other organs. Finally, extramedullary stimulation in the brain can also activate the emetic centre.

Physicians trained in paediatric care are highly sensitized to the dangers of fluid losses from the GI tract and the dangers of dehydration in children who are suffering from gastroenteritis. However, they need to be equally aware of alternate explanations which while less common, can be life threatening.

source: www.wikipedia.org

Part 2: Paediatric Death Review Committee and the Medical Community

Case Review #1

Cerebral Edema and Meningitis

Previous Medical History

This 22 month-old boy was delivered by a full term normal delivery in 2009. There were no neonatal problems. His birth weight was 3.7 kg. He was seen in the emergency department (ED) at a local hospital on February 20, 2011 with a history of diarrhoea and vomiting. A diagnosis of gastroenteritis was made. He was released.

Terminal Events

He presented to the ED at the same hospital at 0840 hours on April 8, 2011 with a four day history of fever and vomiting. He was taken to a walk-in clinic on April 6. No source of fever was identified. The fever persisted. He was taken to the family physician on April 7 where the family physician prescribed Amoxil (three doses given) for a presumed throat infection. His immunizations were up to date. The following day he remained febrile and was reported as being lethargic. Two episodes of diarrhoea were recorded in the history (the parents subsequently stated that there was no diarrhoea). His vital signs on admission to hospital were; temperature 36°C, respiratory rate 34/min, heart rate 122/min, SaO_2 99% (blood pressure was not recorded). His weight was 10.6 kg. A diagnosis of gastroenteritis and dehydration was made, and a bolus of 40 ml/kg of 0.9 % sodium chloride (NaCl) was given intravenously, as was Ibuprofen. He was admitted to the paediatric ward. Blood work was taken for a complete blood count, urea & electrolytes as well as a blood culture (results were negative). The first sodium level was 130 mmol/L. A second bolus of 0.9 NaCl was ordered at 1330 hours. He was then started on an intravenous (IV) infusion of 5% dextrose 0.9 NaCl + 20 mmol KCL (potassium chloride) at 60 ml/hr.

The initial assessment on the ward described him as being lethargic and irritable. His skin turgor was described as good and mucous membranes as being dry. His vital signs were temperature 36°C, heart rate 130/min, respiratory rate 28/min. He remained afebrile for the rest of that day and was passing urine.

At 0745 hours on April 9 his temperature spiked to 38.6°C (axilla) with pulse 145/min. He was prescribed Ibuprofen and acetaminophen. The IV infusion was left unchanged at 60 ml/hr. He remained febrile for the whole morning with a maximum temperature of 39.1°C. The IV infusion rate was reduced to 50ml/hr at mid day and then to 30 ml/hr at 1900 hrs. The child was reported as either irritable or sleeping during this period. The temperature spiked again to 40.4°C at 2105 hours at which time he appeared lethargic.

Part 2: Paediatric Death Review Committee and the Medical Community

His condition remained unchanged the following day except that he was no longer febrile. The IV infusion was changed to 5% dextrose 0.45 NaCl with 40 mmol KCl at 1915 hours. This was to be run at 30 ml/hr. The child was still lethargic and irritable. He vomited at 2115 hours. At around 2120 hours the child became unresponsive and had a seizure. He was intubated and ventilated. A CT scan showed cerebral edema with effacement of the basal cisterns and probable tonsillar herniation. A nearby Paediatric Intensive Care Unit (PICU) was contacted. They advised giving a bolus of 3% saline as well as Ceftriaxone and Acyclovir. He was transferred to the PICU and after a period of assessment, neurologic determination of death was established. A post mortem lumbar puncture (LP) showed turbid cerebral spinal fluid (CSF). Pneumococcus was identified by polymerase chain reaction (PCR).

Postmortem Findings

A post mortem examination was not conducted.

Cause of Death:	Cerebral edema due to Pneumococcal meningitis Contributing factor: Hyponatremia
Manner of Death:	Natural

Comments and Issues Raised

This young boy died from cerebral edema secondary to untreated Pneumococcal meningitis. This case was referred for review to the Paediatric Death Review Committee (PDRC) because of concerns about the fluid management and development of acute hyponatremia. Although the approach to fluid management was probably a contributory factor in development of cerebral edema, (he received 3.2 litres of IV fluid and his total body water was 6 litres), of more concern was the fact that the diagnosis of meningitis was not considered in a child presenting with fever, lethargy and irritability. The CBC and white blood cell differential pointed to a bacterial infection. The treating physicians appeared to have not considered other possibilities beyond a diagnosis of gastroenteritis, for which supporting evidence was limited. The fall in sodium to 126 mmol/l contributed to the development of cerebral edema. The PDRC wondered what rationale there was for the amount of fluid given.

Areas of concern

1. **The correct diagnosis**

   The correct diagnosis was not made in a child who was persistently ill with a fever and lethargy.

   The initial white blood cell count (WBC) was elevated at 13.5 with a left shift and toxic granulation. The PDRC wondered why a lumbar puncture, to rule out meningitis, was not considered given the WBC abnormalities, lethargy and fever in this child. Early diagnosis and treatment is of paramount importance in prognosis for this potentially lethal infection.

2. Confirmation bias

A common error which the PDRC sees frequently is in labelling an illness in a child with vomiting. Confirmation bias may have caused the physicians not to look beyond their admitting diagnosis.

The PDRC acknowledges that they have seen several cases in which vomiting is labelled as gastroenteritis in the absence of any diarrhoea. In health care, it can become a compelling challenge to generate sufficient impetus to cause healthcare providers to re-examine their initial diagnosis. An open mind and an early index of suspicion can be invaluable in this regard.

3. Fluid management/hyponatremia

The attached table sets out with clarity the serum sodium levels of this child. Although his death was most certainly causally related to his Pneumococcal meningitis, a tenet of good care is to ensure that serum electrolytes are maintained as close to normal as possible. On April 10, his serum sodium fell as low as 126 mmol/L, which can, in and of itself, cause cerebral edema.

The PDRC felt that this may have worsened his neurological state, although again, it would not have been causative in his death.

Recommendations

1. *That the Office of the Chief Coroner report this death in the Annual Report of the Paediatric Death Review Committee and Deaths Under Five Committee.*
2. *That the local hospital conducts a Quality Review of this death specifically examining:*
   - *i. Alternate diagnosis for child presenting with vomiting, lethargy and fever;*
   - *ii. The indications for a septic work-up including a lumbar puncture;*
   - *iii. Fluid and electrolyte management during rehydration therapy.*

   This review should be undertaken by the Department of Paediatrics and the Emergency Department. The recommendations of the review should be shared with the Paediatric Death Review Committee.

Date/ Time (hrs)		Na	K	Urea	Creatinine	WBC	PMN	Band	Comment
8 Apr	10:05	130	4.7	4.6	27	13.5	7.8	3.2	Left shift. Toxic granulation. Dohle bodies.
9 Apr	08:55	134	2.7						
	14:52	137	2.8			5.3	2.3	0.48	Toxic granulation. Dohle bodies. Left shift.
	17:57	133	2.9	1.1	27				
10 Apr	13:17	136	2.6			2.4	0.41	0.65	Toxic granulation. Dohle bodies. Left shift.
	18:10	129	3.1						
	21:40	126	4.2	1.8					
	23:41	136	2.5			3.5	0.46	0.7	Toxic granulation. Dohle bodies. Left shift.

Part 2: Paediatric Death Review Committee and the Medical Community

Case Review #2

Diabetic Ketoacidosiss

Past Medical History

This 2 year, 11 month-old, was a previously healthy girl. She had mild jaundice as an infant. She was followed regularly by her family physician. She was seen for intercurrent illnesses as required. Her final visit to her family physician was on May 18, 2010 for vomiting and diarrhoea. A diagnosis of gastroenteritis was made. Her last recorded weight in the family physician's chart was 23 lbs 7 oz on December 22, 2008.

Terminal Events

The Coroner documented that according to her parents, she had been unwell for 2-3 days with vomiting and abdominal pain. She was lethargic and eating very little. She complained of thirst and was constantly asking for something to drink. She also had a large increase in her urine output. She usually wore pull-ups at night and was continent during the day. She was unable to control her urine and she went through approximately 30 diapers in two days.

On August 29, 2010, she was seen in the Urgent Care Clinic at 0805 hours. Her weight was recorded as 11 kg. No vital signs were recorded. Documented history was vomiting since the previous day, 3 – 4 times a day. Decreased appetite and increased thirst were noted. No fever was present and decreased sleep was reported. Abdominal pain was present and her bowel movements were normal. Family history for diabetes mellitus was negative.

The examination documented a clear chest. "Soft abdomen, NAD. HEENT normal." Diagnosis was viral gastroenteritis. The plan was for Pedialyte and Powerade PRN. Also, the family were to return if she developed a fever.

That evening her parents reported that she remained unwell. Her breathing was abnormal in that it was rapid and deep. They put her to sleep in their bed. In the middle of the night her breathing had slowed and was regular. In the morning she was found with vomitus in her mouth and her extremities were cold. Parents called emergency medical services (EMS) and started cardiopulmonary resuscitation (CPR). She was intubated and an intraosseous line (IO) was inserted. She was taken to a local hospital and arrived at 0726 hours.

She was vital signs absent (VSA) on arrival. Her limbs were noted to be stiff. Three doses of Epinephrine and one dose of Atropine were given via the IO. She received three boluses of normal saline. Her glucometer blood glucose read critically high. Resuscitative efforts were stopped due to no response and she was pronounced deceased at 0739 hours.

Post Mortem Examination Findings

Her weight was 15kg. There were bilateral pleural effusions; 120 ml on the right and 190 ml on the left. The lungs showed marked pulmonary edema and evidence of aspiration. The intestinal tract showed hemorrhagic change and microscopic autolysis. Microscopy of the kidneys showed prominent subnuclear vacuolization, (Armanni-Ebstein Nephropathy -- a histologic feature of ketosis). Pancreatic islets were subjectively fewer in concentration, but histologically unremarkable. Cultures were negative.

Her vitreous glucose was 55.5 mmol/L, sodium 140, potassium 20 (not unexpected in the post mortem period), chloride 111, urea 27, creatinine 70 and with 2+ ketones. Urinalysis revealed 3+ glucose, with testing for ketones not done.

Toxicology showed an acetone level in the femoral blood of 28mg/100ml. Skeletal survey was negative.

Cause of Death:	Diabetic Ketoacidosis (DKA)
Manner of Death:	Natural

Areas of Concern

1. **Diagnosis of Diabetic Ketoacidosis (DKA)**
   The history, obtained from the parents after her death by the investigating coroner, of thirst and markedly increased urination followed by lethargy is typical of the first presentation of Type 1 diabetes. It is unclear exactly how much of this history was provided to the physician in the Urgent Care Clinic. The physician did note increased thirst. The usual follow up question would be regarding potential increased urination. Urine output was not documented. The physician did record that there was no family history of diabetes. It appeared from the review of the record that the physician had considered diabetes in his/her differential diagnosis.

2. **Absence of Vital Signs in an Ill Child**
   There were no vital signs recorded at the urgent care clinic and the weight of 11 kg may have been inaccurate as the post mortem weight was 15 kg. The PDRC has observed that lack of vital signs is a recurrent issue with respect to care in walk-in clinics.

3. **Diagnosis of Gastroenteritis in the Absence of Diarrhoea**
   In addition, the diagnosis of gastroenteritis in the absence of diarrhoea, (normal bowel movement documented), could be questioned. The overall presentation was in keeping with the diagnosis of Type 1 diabetes.

Part 2: Paediatric Death Review Committee and the Medical Community

Mortality and causes of death have been studied in a Swedish population-based cohort of 4919 childhood onset IDDM (insulin dependent diabetes mellitus) cases from 1977 to 1995. Twenty males and thirteen females with IDDM died before the age of 28.5 years. Seven patients died of ketoacidosis, four at onset of diabetes. Nine cases were found 'dead in bed', having been seen apparently healthy 1-2 days before death. One of these cases had signs of cerebral hemorrhages at autopsy and another one had signs of bite marks in the mouth, but otherwise all autopsies were normal and no evidence of alcohol or other intoxication was found[4].

The blood acetone level of 28mg/ml at post mortem is consistent with DKA. In a series of 13 deaths attributed to DKA the acetone levels ranged from 8 to 49 mg/100ml[5]. This was further confirmed by a vitreous glucose level of 55.5 mmol/L at post mortem examination.

Recommendations

1. *The Medical Director of the Urgent Care Clinic should receive a copy of the "terminal events" section of this report, and conduct a review of the case focusing on:*
    - i. *the history taken by the physician*
    - ii. *the lack of vital signs. For example, the family was instructed to return if a fever developed, yet no temperature was taken on the visit. In addition, tachycardia or hypotension may have been an indication of hypovolemia.*
2. *The care provided by the physician in this case should be reviewed by the College of Physicians and Surgeons of Ontario – Fitness to Practice Committee.*
3. *The death of this child and the misdiagnosis of diabetic ketoacidosis as gastroenteritis should be featured in the Office of the Chief Coroner's Annual Report of the Paediatric Death Review Committee and the Deaths Under Five Committee.*
4. *The Chair of the Paediatric Death Review Committee (PDRC) should share a redacted copy of this report with the Canadian Medical Protective Association (CMPA); and, a teleconference should be arranged between the PDRC and CMPA to discuss strategies to ensure that physicians operating walk-in clinics have the ability to complete vital signs on children who are ill.*

[4] Diabet Med. 1995 Jul;12(7):607-11

[5] Brinkmann, et al., Int. J. Legal Med. 111:115-119, 1998

Part 2: Paediatric Death Review Committee and the Medical Community

Challenges with Echocardiography in the Paediatric Population

by Dr. Alan Hudak, MD, FRCPC

Case History

Medical review followed the death of a fourteen year-old girl who at age twelve had complaints of shortness of breath, dizziness, and vertigo while horse back riding. Several investigations were initiated at that time including a cardiopulmonary stress test which demonstrated abnormalities of maximum oxygen consumption and arterial oxygen saturation response to exercise. An echocardiogram was reported as normal although an independent review at the time of the Paediatric Death Review Committee (PDRC) evaluation documented right ventricular hypertrophy. A holter monitor assessment was normal.

An electrocardiogram (ECG) completed eleven months after her initial complaint demonstrated right ventricular hypertrophy prompting completion of a second echocardiogram. This study was reported as "borderline abnormal" although review facilitated by the PDRC noted clear abnormalities with findings compatible with pulmonary hypertension.

Terminal Event

One year later she presented to the Emergency Room with persistent vomiting and diarrhoea. She was noted to be hypotensive and hypoxemic. A chest x-ray demonstrated pulmonary edema with cardiac enlargement. She was transferred to a tertiary care hospital where an echocardiogram showed pulmonary hypertension. Despite aggressive therapy, her pulmonary edema worsened with progressive respiratory distress, hypotension and cardiac arrest. Resuscitation was unsuccessful.

Post Mortem

Post mortem examination provided the cause of death as "acute congestive heart failure due to pulmonary veno-occlusive disease."

Comments and Issues Raised

PDRC review of this case identified concerns about the approach in the review and reporting of cardiac testing in adolescence; specifically ECG tracings and echocardiograms. Retrospective review indicated that abnormalities were present at least two years before the death. An independent review by a paediatric cardiologist concluded that the abnormalities on echocardiogram should have been recognized, presenting an opportunity for earlier diagnosis and treatment.

Recommendations

The Office of the Chief Coroner of Ontario provided recommendations to the Provincial Council for Maternal and Child Health (PCMCH) to develop and/or ensure that quality practices are in place related to the reading and interpretation of paediatric echocardiograms.

Part 2: Paediatric Death Review Committee and the Medical Community

Response of the Provincial Council for Maternal and Child Health (PCMCH)

source: www.wikipedia.org

A paediatric echocardiography working group was established in 2010 publishing their findings in a 2011 report. The working group analyzed the current state of practice and access related to performance and interpretation of paediatric echocardiograms, as well as reviewing the availability and utilization of clinical guidelines and standards. It was noted ***"that paediatric cardiac disease may be difficult to detect unless the personnel performing and/or interpreting the diagnostic tests know exactly what they are looking at. Recognition of paediatric cardiac disease requires specialized knowledge that is different from that required for adult cardiac disease. However many paediatric echocardiograms in Ontario are performed and interpreted by cardiac sonographers and physicians who do not have expertise in the unique aspects of paediatric echocardiography."***

The working group concluded that ***"it is essential that an environment be created that enables and compels paediatric echocardiograms to be performed and interpreted by those with the requisite skills and knowledge and within appropriate echocardiography laboratory facilities".*** The group further recommended that appropriate training guidelines and opportunities be in place for sonographers and physicians with professional regulation for both groups as well as certification of all laboratories involved in paediatric echocardiograms. An additional recommendation was made for the establishment of a **Paediatric Echocardiography Provincial Planning Committee** to plan and implement these recommendations. This group has been established.

The Office of the Chief Coroner of Ontario is appreciative of the efforts made by PCMCH. Unfortunately this case was not the first with similar issues that had been identified but certainly highlighted the ongoing problems being faced by the paediatric population. The implementation of the recommendations made by the working group will address those concerns.

Part 2: Deaths Under Five Committee

Deaths Under Five Committee (DU5C)

Introduction

The Deaths Under Five Committee of the Office of the Chief Coroner meets at least six times per year for the purpose of comprehensively reviewing all the deaths of children less than five years of age investigated by a coroner in Ontario. It is a multidisciplinary committee and attendees typically include three to four senior forensic pathologists, two senior coroners, five or more senior homicide detectives, child maltreatment experts, a crown attorney, a health statistician and epidemiologist, a child welfare consultant, a Health Canada Product Safety Representative and senior staff from the Office of the Chief Coroner.

One of the challenges the reviewers face is trying to properly assign manner and cause of death. This is most challenging in children less than one year of age, when an autopsy has not clearly demonstrated a cause of death. It is not uncommon that even with the most qualified and experienced forensic pathologists performing the autopsy, the cause of death remains undetermined.

Sudden Infant Death Classification Project Canadian Chief Coroners and Medical Examiners

At the 2010 annual meeting of the Canadian Chief Coroners and Medical Examiners (CCME), it was identified that there was a lack of consistency in the classification of infant deaths across provincial and territorial jurisdictions. The CCME struck a Working Group lead by a member of the British Columbia Coroner's System to address this issue. Members of the Deaths Under Five Committee have actively participated with the working group.

The group has made great strides in achieving their mandate to standardize the certification and classification of unexpected infant death across Canadian jurisdictions. One of the significant changes reflected in the recently released *fifth* version of the Sudden Infant Death Classification (chart follows) involves the cause of death now being provided as undetermined in cases where a conclusive finding could not be achieved despite a comprehensive investigation. Previously, based upon a 2005 publication of the National Association of Medical Examiners, many death investigation jurisdictions had adopted use of the often confusing Sudden Unexpected/Unexplained Death in Infancy on the Medical Certificate of Death.

The number of cases in each category reviewed by the DU5 in 2011 is included in the right hand column of the chart.

In 2011, 80 of 98 deaths reviewed at the Deaths Under Five Committee occurred in infants who were less than one year of age.

Part 2: Deaths Under Five Committee

Sudden Infant Death Classification					2011 Reviews
	Autopsy Findings	**Investigative Findings**	**Cause of Death on Death Certificate**	**Manner of Death**	**DU5C**
1	Autopsy reveals a definitive cause of death (pneumonia, head injury, etc.)	Variable	As per the autopsy/ investigative findings	Based on autopsy/ circumstances	**11 Total** 1 natural 7 accidental (3 of which were bed sharing accidental deaths) 3 homicides
2*	No anatomical or toxicological cause of death identified	Negative • child found supine or prone • no evidence of sleep- associated circumstances** • may include exposure to environmental tobacco smoke or in utero tobacco use	Part Ia- Undetermined Part Ib- Part II- **---OR---** Ia- Sudden Infant Death Syndrome (SIDS) Ib- 2-	Undetermined Natural	**4 Total** 3 undetermined undetermined-no risk factors 1 SIDS
3A	No anatomical or toxicological cause of death identified	Presence of sleep associated circumstances ** Absence of social risk factors***	Ia- Undetermined Ib- II- **---OR---**	Undetermined	**60 Total** 33 Unsafe sleep 25 Bed sharing
3B	No anatomical or toxicological cause of death identified	May have sleep associated circumstances** Presence of social risk factors ***	Ia- Undetermined Ib- II-Unsafe Sleep Environment (description in parentheses)	Undetermined	2 No sleep issues but risk factors
4[1]	No anatomical or toxicological cause of death identified	Findings in investigation/ autopsy, examples include: • autopsy findings for which the differential diagnosis includes non- accidental injury (ex: healing fracture, bruises, etc) • death of a previous child in suspicious circumstances • significant toxicological findings for which there is an inadequate explanation	Ia- Undetermined Ib- II-	Undetermined	5 deaths
					80 Total

Part 2: Deaths Under Five Committee

*** A death may not be considered in Category 2 if any of the following is/are present:**

- Presence of sleep associated circumstances (described below):
- Presence of social risk factors (described below)
- Anatomical or toxicological findings that do not establish a cause of death, but for which the differential diagnosis includes abuse, and the caregiver has no explanation for the findings, or the caregiver's explanation for the findings is unwitnessed, or undocumented

**** Sleep associated circumstances include:**

- Infant died while bed-sharing with a person or pet (adult, toddler, child, cat, dog, etc.)
- Infant died during sleep on a surface not intended for infant sleep (adult bed, waterbed, sofa, child carrier, car seat, non-approved playpen or bassinet)
- Infant died while sleeping in a cluttered sleep environment (bedding, toys, clutter in the sleep area that represent a significant asphyxial potential)

***** Social Risk Factors, including, but not limited to:**

- Previous involvement with child welfare agencies, substantial mental health histories in caregivers, domestic violence in the home, alcohol or substance abuse in the caregivers, concerning, but non-specific investigative findings (e.g. inconsistent accounts of circumstances surrounding the death)

[t] A death should be considered as Category 4 if:

- Anatomical or toxicological findings that do not establish a cause of death, but for which the differential diagnosis includes non-accidental injury, AND the caregiver's explanation of these findings are unwitnessed or undocumented.

As evidenced from review of the chart, complete consensus has not been achieved. There exists a difference of opinion regarding Category 2 deaths, and whether the cause of death should be "SIDS" or "Undetermined." The Deaths Under Five Committee will continue with the terminology of SIDS as it is felt that these are a unique category of natural deaths. Historically, SIDS categorization allowed focused research with significant public health benefit reflected in the 53% reduction with the Back to Sleep Program.

Given our experience supported by medical literature, members of the Deaths Under Five Committee are of the opinion that sleep-associated circumstances may have a direct contributory role to infant death. We will therefore continue to include sleep associated circumstances on the Medical Certificate of Death to enhance identification of this category of infant deaths, reflecting the comprehensive investigative work and ensuring inclusive data is available for research and analysis.

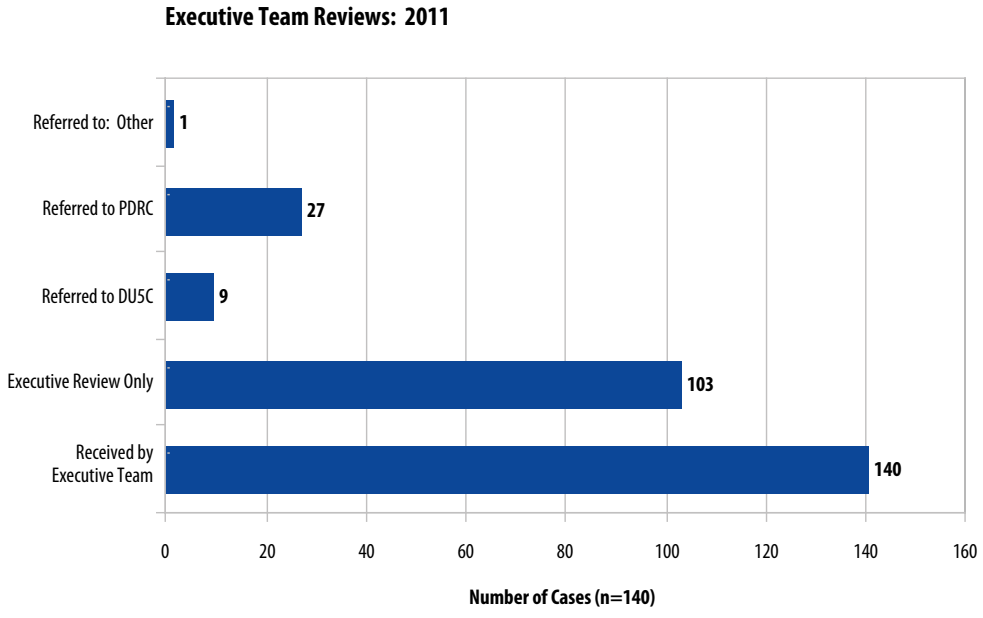
The working group has recognized that absolute consistency in infant death classification may be difficult. Consensus was reached that it is more important to focus on standardized, consistent, nationwide data collection and ensuring this data is accessible to researchers. The Working Group presented their findings at the June 2012 CCME meeting, with unanimous acceptance by the group. The future plan is to work towards a nationwide standard data collection process, within the context of a nationally uniform process of infant death investigation.

Part 2: Deaths Under Five Committee

Deaths Under Five Committee Referral Statistics

All deaths of children less than five years of age are received, tracked and triaged by the Executive Team. Cases are referred by the Regional Supervising Coroners; they are processed, but not necessarily reviewed in the year of receipt. The data on this page represent referrals received and reviewed by the Executive Team in 2011; cases reviewed by the complete committee in 2011 are discussed on the next page.

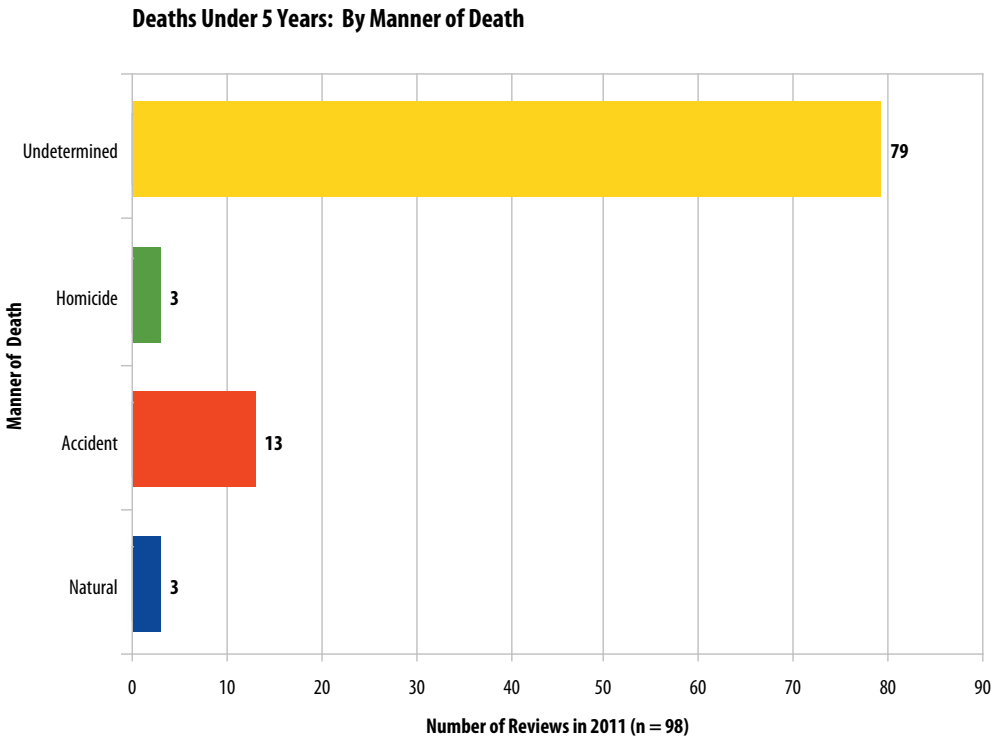
- In 2011, 140 cases were received and reviewed by the Executive Team.
- Of the 140 cases, 86 (61%) were natural; 36 (26%) were accidental; 10 (7%) were homicides; and, 8 (6%) were undetermined.
- 74% (103/140) were reviewed by the Executive Team and a final report was issued.
- 6% (9/140) were reviewed by the Executive Team and referred to the Deaths Under Five Committee (DU5C) for further review.
- 19% (27/140) were reviewed and referred for further review by either the Child Welfare or medical experts at the Paediatric Death Review Committee (PDRC).
- 1% (1/140) was referred to other expert committees (i.e. Domestic Violence Death Review Committee (DVDRC) for review.



Part 2: Deaths Under Five Committee

Deaths Under Five Committee
2011 Reviews by Manner of Death

- In 2011, the Deaths Under Five Committee (DU5C) reviewed 98 deaths.
- Of the 98 deaths reviewed by the DU5C, 54 (55%) were male; 44 (45%) were female.
- The majority of deaths, 79 (81%) were classified as undetermined.
- Accidental deaths accounted for 13 (13%) of the deaths.
- 3 (3%) deaths were natural; and 3 (3%) were classified as homicides.



Part 2: Deaths Under Five Committee

Deaths Under Five Committee Reviews by Manner of Death 2009-2011

In 2011, a decision was made to reduce the number of clearly natural deaths reviewed to allow for a concentration of the Committee's time on cases with challenging issues.

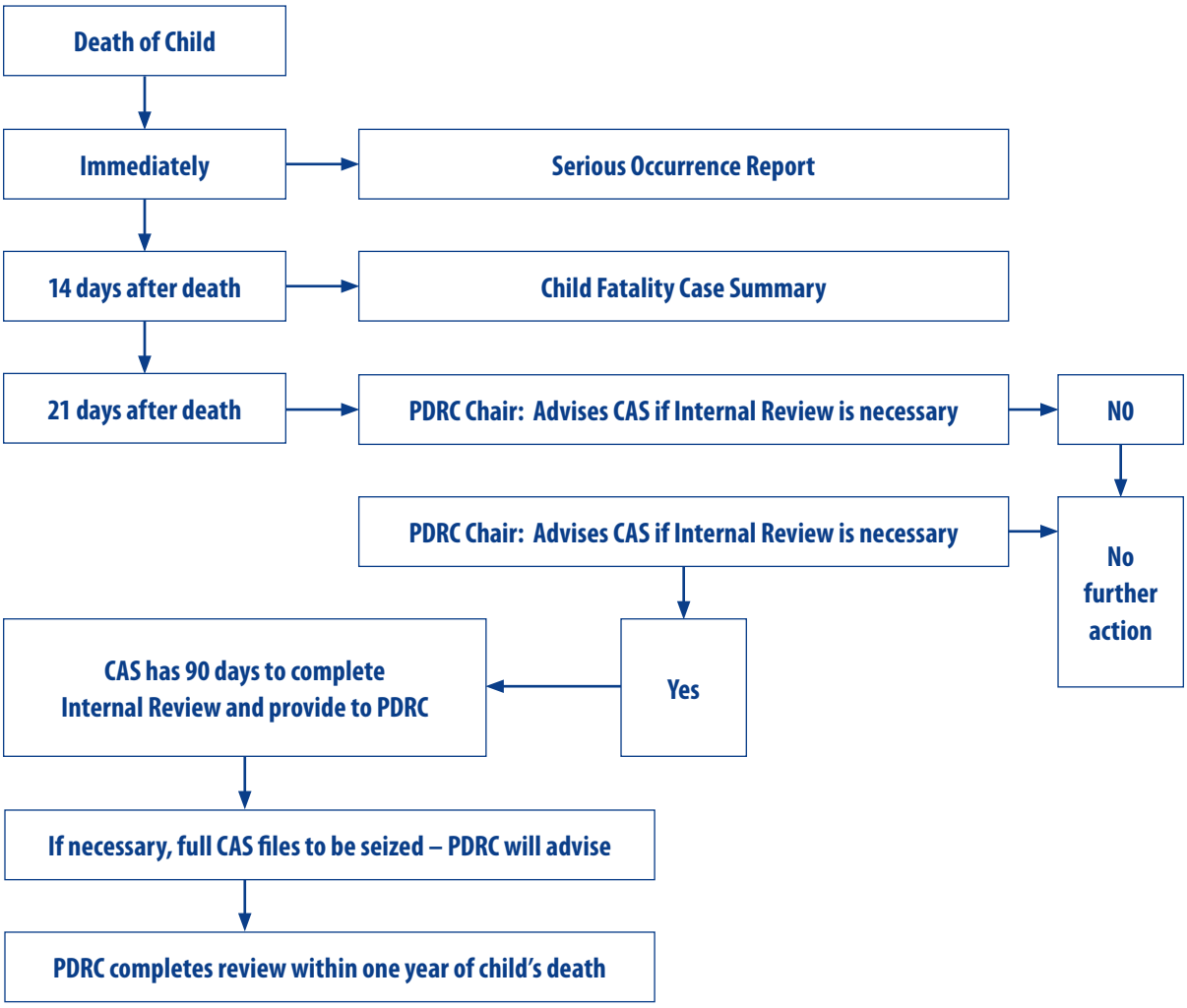
Year	Natural	Accident	Homicide	Undetermined	TOTAL
2009	16	14	2	60	**92**
2010	17	14	4	73	**108**
2011	3	13	3	79	**98**

Part 3: Ontario's Children's Aid Societies and the PDRC

Introduction

In Ontario, child welfare services are currently provided by 47 Children's Aid Societies (CAS), six of which are designated Aboriginal agencies. Each CAS is an independent, non-government agency governed by a board of directors and funded by the Ministry of Children and Youth Services. In 2006, the Office of the Chief Coroner and the Ministry of Children and Youth Services entered into a Joint Directive and Memorandum of Understanding which directs and guides Children's Aid Societies regarding the process of reporting and reviewing all child deaths where the child and/or family has had CAS involvement within the 12 months prior to the death.

The chart below shows the flow and timelines as outlined in the Joint Directive for Child Death Reporting and Review:



Part 3: Ontario's Children's Aid Societies and the PDRC

Internal Child Death Reviews by Children's Aid Societies

Internal Child Death Reviews must be completed by Children's Aid Societies under the Joint Directive. This is required whenever:

1. The death of a child occurs;
2. That child is the recipient of current or recent service from a CAS; and
3. When a death may be a result of abuse or neglect or occurs under questionable circumstances.

An Internal Child Death Review is conducted by the involved CAS in order to investigate thoroughly the death and the context within which the death occurred. The review seeks a contextual understanding of the details of intervention, decision-making and potential oversight exercised by the CAS. It makes recommendations for the improvement of internal or external systems and structures to reduce the risk of future deaths of children served by the Society.

The Internal Child Death Review seeks to understand the circumstances relating to the child's death and to convey this understanding to the relevant staff, managers and collateral service providers in a manner that provides clarification, support and the capacity to continue to provide services.

The PDRC, upon reviewing the CAS Child Fatality Case Summary Report and the Coroner's Investigation Statement, considers the following specific criteria when requesting that a CAS conduct and forward an Internal Child Death Review to the PDRC. This list is not exhaustive.

- **CAS involved within 12 months**
- **Sudden, unexpected deaths, including most accidents, suicides, homicides and undetermined**
- **Some natural deaths (e.g. SIDS)**
- **Potential for prevention of the death with intervention by the CAS**
- **CAS file open for reasons that may be related to the death**

An Internal Review of a child death is undertaken by the agency for the purposes of learning. Internal reviews, when shared among Societies, have the potential to promote an enhanced quality of practice within the broad field of child welfare. One of the goals of the Annual Report of the PDRC is to share the lessons learned through individual case reviews (both PDRC and Society) with other agencies across the province in an effort to improve the quality of child protection services provincially.

Part 3: Ontario's Children's Aid Societies and the PDRC

The purpose of completing Society Internal Child Death Reviews, as per the Joint Directive and Guidelines, is to review and analyze the service agency's:

- Compliance with standards
- Adherence to internal policy/practice
- Decision-making

Internal reviews are meant to include:

- Source materials, i.e. file review/interviews/policies
- A thorough summary of the CAS history and relevant events
- Circumstances of the death
- An expert External Reviewer on the team (see below)
- Findings of the review
- Recommendations to prevent future deaths (flowing from the evidence of the case)
- A plan to implement recommendations
- Lessons learned; identifying strengths and weaknesses in practice, policy, systems, decision-making, case management, supervision and organizational structure with a goal to prevent future deaths without ascribing blame to any individuals

"The farther backward you can look the farther forward you are likely to see."

Winston Churchill

In choosing an External Reviewer, the Society should:

- Avoid a reviewer with real or perceived conflict of interest or with an imbalance of authority, control or power;
- Avoid a reviewer with previous carriage or supervision of the case;
- Ensure the reviewer has a broad knowledge of child welfare from front line, management and systemic perspectives;
- Ensure the reviewer has knowledge of child fatality investigations/reviews;
- Ensure the reviewer is objective and able to conduct critical analysis and make meaningful and independent recommendations.

Part 3: Ontario's Children's Aid Societies and the PDRC

CAS Responses to PDRC and Internal Death Review Recommendations

Following the CASs' receipt of individual PDRC reports, Societies consider the PDRC report, implement the recommendations as appropriate and incorporate the recommendations addressed to them into written progress reports submitted to the Ministry of Children and Youth Services Regional Offices. Ministry Regional Offices are responsible for follow-up with individual CASs on a quarterly basis regarding the actions they have taken to respond to the specific Internal Review and PDRC report recommendations. The table on the following two pages shows examples of actions taken and changes made within agencies as a result of lessons learned from recent Society Internal Death Reviews and PDRC reviews.

Part 3: Ontario's Children's Aid Societies and the PDRC

All CAS first responders and screeners have been directed to secure all relevant documentation and records held by any other Child Welfare Agency who has had previous contact with the subject family. This information is expected to be secured by intake and passed to ongoing services.
Implementation of a policy which identifies unsafe sleeping environments. This includes clear instructions to staff to take immediate action when a child is identified to be sleeping in an unsafe environment, at minimum, consultation between worker and supervisor, and can also include seeking legal advice.
The delivery of training on comprehensive assessments and service plans which considers key risk factors and the parents' motivation and ability to change.
A water safety policy was implemented for all foster and kinship homes. The policy addresses guidelines for all homes with water features such as pools, ponds and hot tubs and that all homes must comply with municipal by-laws. Assurance of compliance of the home with these guidelines will be undertaken each spring by Society staff and the care provider.
A full community case review was held to conduct a comprehensive review of the family file. A risk assessment took place, and the family, including the children, attended for referred counseling.
A verification decision was reviewed and a decision made that the parents would be placed on the Child Abuse Registry.
Ongoing training was provided by an outside consultant on the link between assessment, planning, case notes, goal setting, protective factors and safety planning. Training took place on completing the risk assessment and family strengths and needs assessment, as well as reviewing the importance of family history.
Senior Management reviewed with Service Managers the practice of reviewing previous supervision notes, when they receive a new case/case transfer.
St. John's Ambulance training was provided for all resource parents who are caring for any child who has abnormal health and/or medical issues.
Suicide awareness training was secured for all Adolescent Unit Staff. It will then be made available to all staff in other service areas.
The two youngest children in a specific home were psychologically assessed, as per recommendations.
Protection staff now contract with a third party for the supervision of contact between a child and a person who poses a risk to the child.

Part 3: Ontario's Children's Aid Societies and the PDRC

A Serious Occurrence Team was created that investigates Serious Occurrences such as investigating community caregivers and deaths of children when there is no open file at the Society.
Several Societies and police have revised the CAS/Police protocol for investigating child maltreatment and deaths.
A supervision note template was developed which will enhance consistency and support clinical supervision.
Upcoming training will ensure that follow-up with collaterals is done to confirm clients are participating in services and that more attention is paid to how the impact of domestic violence affects children.
Quarterly file audits have been initiated for investigations and are ongoing to ensure complete documentation.
Training was provided on drug abuse, the community's drug culture and neglect, and how these can impact on parenting.
Reviews occurred on a Society's relationship with community partners and service delivery protocols which identified priority service partners. Supervisors were assigned to sit at various community planning tables. The Society was attempting to include external service professionals at internal planning meetings, with the client's consent.
A public health nurse was seconded to the agency to accompany workers on investigations involving young parents.
The After Hours Program was enhanced to allow workers access to the online system for checking file history.
A High-Risk Infant Protocol was developed with external service providers.
The importance of reassessing risk when there is a change in family structure or situation was reviewed with protection workers.
A review on how to educate young mothers on the risks of bed-sharing was undertaken with the consultation of community partners.
Training was developed for resource workers in identifying safety concerns and risks in foster homes on an ongoing basis.
A series of workshops was provided for staff that stresses the importance of developing strong client engagement skills as well as a comprehensive training on motivational interviewing.
A safe sleep practice philosophy position was adopted. Information is shared with all parents of young children through a number of means directly as well as on the agency's website; a public service announcement has also been developed.

Part 3: Ontario's Children's Aid Societies and the PDRC

Deaths of Children in 2011 Reported by a Children's Aid Society

As per the Joint Directive for the reporting and reviewing of all child deaths known to a Children's Aid Society within 12 months of the death, **109** child deaths were reported by a CAS to the PDRC in 2011.

The CAS that provided service to the family submitted a Serious Occurrence Report and within 14 days of the death submitted a Child Fatality Case Summary Report to the PDRC. The Executive Committee of the PDRC screened these reports and, within 7 days, a decision was made whether the CAS was required to complete an Internal Review for the purposes of a future PDRC review. The decision to request an Internal Review is based on the criteria set out in the Joint Directive (see pages 43-45).

Most deaths are not reviewed in the year of death due to these timelines, the volume of cases, and the length of time required for completion of the coroner's investigation, including the autopsy report, other tests and DU5C review, if required. Additionally, cases before the criminal courts are generally not reviewed until criminal proceedings are complete.

A brief summary and analysis of the deaths reported in 2011 by a CAS is provided below. As many of these deaths are still under investigation and have not yet been reviewed by the PDRC, the available information is limited. Further analysis of these deaths will be provided in the year in which they are reviewed.

The Executive Committee of the PDRC reviewed all **109** deaths and requested that Society Internal Reviews be submitted in **33** (see chart on next page). In four other cases, a decision is pending the anticipated review by the Deaths Under Five Committee. It was determined that **72** of the **109** cases did not require further review given the nature of the child's death and/or the Society's involvement. The majority of these cases were medically fragile children who died as a result of natural causes, most of whom were in hospital, born prematurely or with complex medical and/or genetic conditions.

Categories of Review:

EXECUTIVE REVIEW ONLY: These are cases which, when reviewed by the Executive Committee of the PDRC it is determined that no further review by the CAS or PDRC is required, as the information available indicated that the death could not reasonably have been prevented or predicted by a CAS or medical intervention. For example, cases where the child's family had no CAS involvement until the injury leading to the death, or the child was known to CAS, but the death was natural and not unexpected, or the child died as the result of an incident unrelated to the family's involvement with CAS.

PENDING DU5C: On occasion, the decision to request an Internal Child Death Review is postponed pending the completion of the coroner's investigation and/or review by the Deaths Under Five Committee when more information will likely be known.

INTERNAL & PDRC REVIEW: If the PDRC requests an Internal Child Death Review, agencies are requested to submit their report in 90 days, and the PDRC has up to 12 months to review the case and issue a report that may contain further recommendations. All cases that have Internal Reviews are reviewed by the PDRC.

Part 3: Ontario's Children's Aid Societies and the PDRC

Children Known to CAS Who Died In 2011

What will happen to the 109 Cases Reported by a CAS to the PDRC Executive Committee in 2011?

33 (30%)	4 (4%)	72 (66%)
• Internal Review Requested • Future PDRC Review	• Pending Deaths Under 5 Committee Review • Possible Internal & PDRC Reviews	• Executive Review Only • Internal Review Requested • No future PDRC Review

CAS Status of Children Who Died In 2011

		In CAS Care	In Home Service
Total	109	24	85
%	100%	22%	78%

17/24 (70%) children in the care of a CAS died of natural causes and were considered medically fragile.

One death of a child in the care of a CAS resulted in the Society being requested to complete an Internal Review and will undergo a PDRC review.

The number of child deaths during this time frame clearly represents a very small percentage of the total number of children and families involved in the child welfare system. It must always be remembered that families who receive service from a Children's Aid Society may suffer from a variety of social ills such as addiction, poverty, unemployment, social isolation, substance abuse and mental illness. Living in a challenged environment may provide some explanation as to why the percentage of children known to CAS who die each year is greater than in the general population.

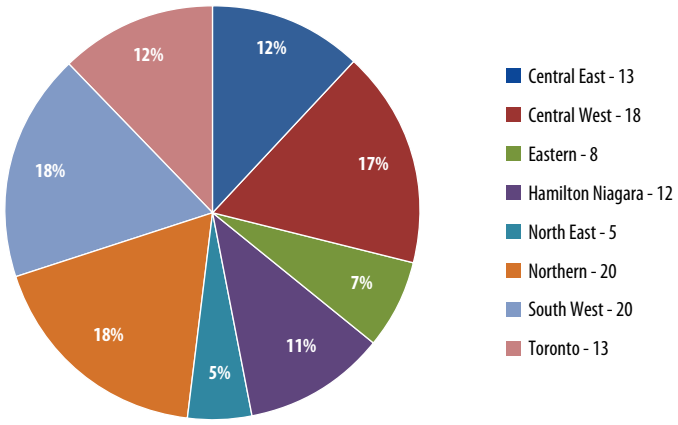
These children are "high risk" and CASs must mitigate their responsibilities to protect a child under the Child and Family Services Act with the desire and rights of a family to raise a child, even when the childrearing situation may be less than optimal. Clearly, this is a very difficult task. The recognition of these challenges is not intended to minimize or rationalize the death of any child; we are all genuinely and seriously concerned whenever a child dies.

Part 3: Ontario's Children's Aid Societies and the PDRC

Deaths Reported in 2011 by Region

The Ministry of Children and Youth Services (MCYS) is divided into nine regional areas that oversee 47 (as of 2012) Children's Aid Societies. The chart below provides a breakdown, by region, of the percentage of deaths reported to the PDRC in 2011. Over 50% of the reported deaths occurred in the North, South West and Central West regions. There were no reported deaths in the South East region.

Cases Reported by a CAS in 2011 by MCYS Region (n=109)



Part 3: Ontario's Children's Aid Societies and the PDRC

PDRC Review of Cases With Children's Aid Society Involvement

The PDRC does not generally review cases in the year of the death. Many of the previously discussed 109 reported cases are still under investigation and have not yet been reviewed. The focus of our analysis from this point in the annual report is on the deaths **reviewed** by PDRC in 2011.

While the PDRC does not assign blame, it does review cases with a view toward prevention. One of the roles of the PDRC is to make recommendations to avoid future deaths in similar circumstances. For example, questions considered include: Could this child's death have been prevented? Could similar child deaths in the future be prevented? If so, how? Given the circumstances of the 2011 case reviews, future deaths might be avoided by the provision of:

- ***Safer sleep environments;***
- ***More vigilant supervision of young children around water and fire starting materials;***
- ***Greater compliance with installation and maintenance of working smoke alarms;***
- ***Development of Suicide Prevention Strategies for youth;***
- ***Enhanced information sharing amongst service providers, including case conferences;***
- ***Community collaboration through joint protocols related to high risk populations (i.e. infants, discharge planning, substance abusing parents, neglect).***

All child deaths are tragic and are usually the result of a number of factors. Occasionally, the actions or inactions by those in a caregiving role (parents and/or systems) have a part in the circumstances of the fatality. The PDRC reviews the circumstances of the death and may make recommendations for consideration by the health and child welfare systems and others with a goal to reduce the number of child fatalities.

It is recognized that the Committee has the benefit of hindsight (which includes access to information that may not have been available prior to the death) when conducting its assessment of agency practices, it is helpful to bear in mind the following questions posed by Dr. Peter Markesteyn (from the Turner Review and Investigation, Newfoundland, September 2006):

- ***What did they know at the time of the events?***
- ***What could they have known, but did not when those events occurred?***
- ***Based on what they knew or could have known, were the decisions appropriate?***

Part 3: Ontario's Children's Aid Societies and the PDRC

2011 PDRC Reviews of Cases with Children's Aid Society Involvement

Demographics from case reviews conducted in 2011 (n=46)

Gender	Males		50%	(23)
	Females		50%	(23)
Age	Age Range	9 days - 19 years		
	Age Groups:	Under 1 year	56.5%	(26)
		1-4 years	19.5%	(9)
		5-14 years	9%	(4)
		15-19 years	15%	(7)
Year of death:	2006		7%	(3)
	2007		2%	(1)
	2008		11%	(5)
	2009		39%	(18)
	2010		41%	(19)
CAS Involvement	Open protection files at the time of death		83%	(38)
	• 8 Intake; 30 Ongoing Services • 2/30 had a Court Order of Supervision			
	Cases closed within 12 months of the death		17%	(8)
	Children in Care of a CAS		11%	(5)
	• 3 Crown Wards • 1 Extended Care and Maintenance (ECM) • 1 Other (in care as a result of the injury that led to the death) • Manner of death: accident (1); undetermined (2); suicide (2)			
Family :	• 8 children were identified as First Nation (17%) • 2 cases involved the deaths of sibling pairs • 4 families had experienced a previous child death • (1 suicide; 3 unsafe sleeping/bed-sharing)			

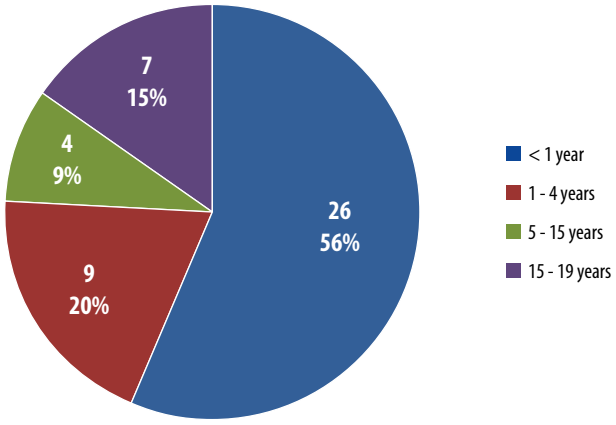
Part 3: Ontario's Children's Aid Societies and the PDRC

PDRC Reviews of Cases with Children's Aid Society Involvement

Age

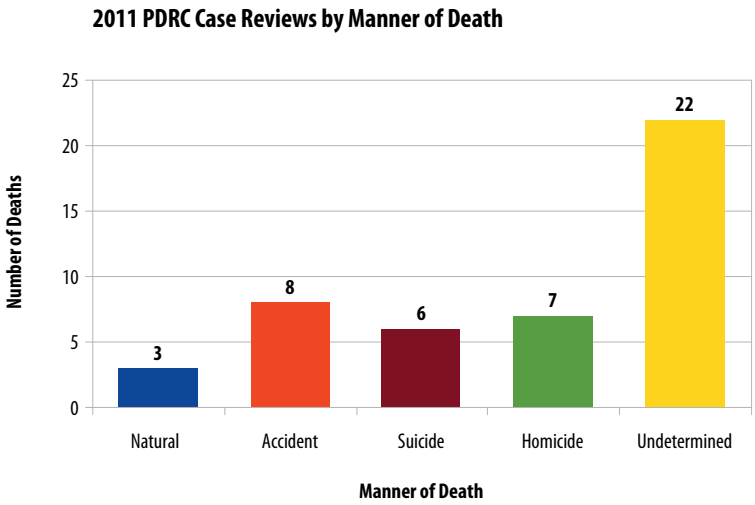
The following charts show ages and the manner of death (explained further on the next page) of the 46 children whose deaths were reviewed by the PDRC in 2011.

2011 PDRC Case Reviews by Age



Part 3: Ontario's Children's Aid Societies and the PDRC

Manner of Death



Death by what means: NATURAL

Deaths of medically fragile children are reported to the PDRC if the CAS had involvement within 12 months of the death and/or if the child was in care, even when the death was expected and occurred under medical care. Due to the nature of a child's illness and/or death, which is often predictable and not directly preventable by a CAS or medical intervention, few of these deaths receive full reviews by the PDRC. However, there are some natural deaths of children known to a CAS that are reviewed by the PDRC, particularly if there were concerns about the child's care.

Three deaths reviewed by the PDRC were classified as Natural. The causes of death for these children were:

- Complications of Congenital Hydrocephalus
- Undiagnosed Metabolic Disorder
- Bilateral acute bronchopneumonia due to combined codeine and morphine toxicity complicating tonsillectomy and adenoidectomy in a child with duplication of CYP2D6 gene

Part 3: Ontario's Children's Aid Societies and the PDRC

Death by what means: ACCIDENT

Eight of the 46 deaths (17%) reviewed by the PDRC in 2011 were classified as "Accident", meaning as a result of an incident that happened without foresight or expectation. Most "accidental" deaths are preventable. One of these children was in the care of a Children's Aid Society. The causes of death for the eight cases classified as Accident were:

- smoke inhalation (4)
- drowning (2)
- complications of solvent intoxication (1)
- craniocerebral crush injury (1)

The four fire deaths were the result of three fires, one of which took the lives of two siblings. None of the homes where the fire occurred had operating smoke alarms. One fire was suspected to have been ignited by a child playing with a caregiver's cigarette lighter. Three of the children had briefly been left unsupervised in their home; one with a pot cooking on the stove and two with an unattended burning wood stove. Their ages ranged from nine months to five and one-half years.

The two drowning deaths also occurred in the absence of adult supervision; one child was left unattended in a bathtub and the other was playing outside alone near a large body of water.

Caregivers must be reminded that careful and constant supervision of young children around ignition sources and bodies of water and the installation and maintenance of working smoke alarms may help reduce or eliminate the majority of 'accidental' deaths in the future.

"We often think that injury events are random "accidents." However, most injuries to children are predictable, understandable and therefore preventable".

(The National Center for Child Death Review - Michigan)

Part 3: Ontario's Children's Aid Societies and the PDRC

Death by what means: SUICIDE

A classification of suicide means the death was the result of an intentional act by a person knowing the probable consequence of what he or she is about to do – that is the commission or omission of an act that results in his or her own death.

The suicide deaths of six youths between the ages of 12 and 19 years were reviewed in 2011 by the PDRC; three were male and three were female.

Two of the six young people were from a First Nation community in Northern Ontario.

Four of the deceased had a history of substance abuse and had consumed drugs and/or alcohol on the day of death. It was known that four of these youth had previous suicidal ideation or attempts and three had experienced a recent suicide of a close family member or friend.

One youth was a Crown Ward and another was on Extended Care and Maintenance (ECM) with a CAS; the other four resided with family members. All six youth came from families with lengthy CAS involvement regarding concerns of neglect, substance abuse and/or spousal violence.

All of these deaths were classified as:

- **Cause of Death:** Hanging
- **Manner of Death:** Suicide

Part 3: Ontario's Children's Aid Societies and the PDRC

Death by what means: HOMICIDE

Seven children's deaths reviewed in 2011 were classified as homicide, meaning the action of one person causing the death of another. These children ranged in age from two months to 16 years.

The PDRC delays review of these deaths until all criminal matters are resolved; the homicide deaths reviewed in 2011 occurred between 2006 and 2010. Criminal charges were laid and convictions registered in all seven deaths; perpetrators were:

- biological parent (3)
- parent's common-law partner (1)
- acquaintance of the parent (1)
- acquaintance of the victim (1)

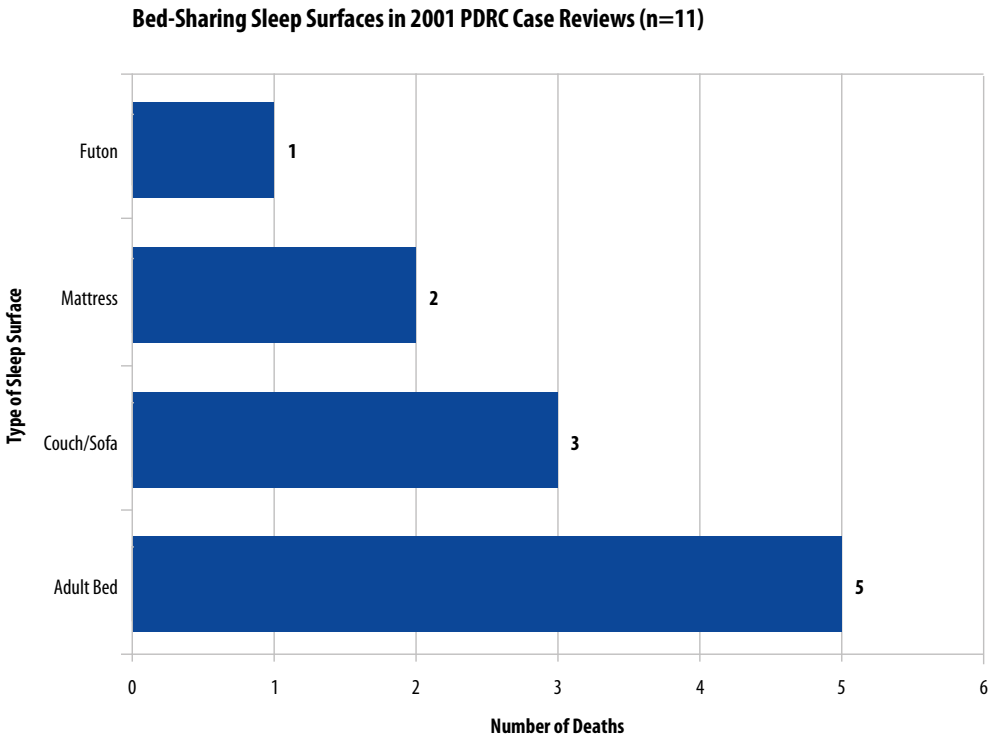
Death by what means: UNDETERMINED

When a complete investigation, including an autopsy and review of the clinical history and evaluation of the scene, does not allow for a clear determination of the manner of death, or there are competing manners of death, the death will be classified as undetermined. Many of the deaths of infants, where no anatomic or toxicologic cause of death is found, are classified as undetermined.

- 22/46 (48%) of deaths reviewed by the PDRC were classified as Undetermined;
- 15/22 (68%) of those deaths involved infants who died while in unsafe sleeping environments;
- 13/15 (87%) of those infants were less than six months of age; two were six and one-half months and nine months old, respectively;
- 11/15 (73%) of the deaths within unsafe sleeping environments also involved bed sharing; in 10 cases, with the mother and/or the father; in one case with the mother and two siblings.

Part 3: Ontario's Children's Aid Societies and the PDRC

The PDRC continues to note a disturbing trend of infant deaths while sleeping in unsafe sleep environments, including bed-sharing (sharing a sleep surface not approved for infant sleep with an adult and/or sibling). The following chart demonstrates the types of sleep surfaces in which the 11 infants, whose deaths were reviewed in 2011, were found:



Part 3: Ontario's Children's Aid Societies and the PDRC

Examples of Two Death Reviews

Review of the Death of PK

Summary of Circumstances Surrounding the Death:

PK was born at 35 weeks gestation and weighed 5 pounds 6 ounces at birth. She was discharged from hospital a week later weighing 4 pounds 10 ounces. At discharge, the plan was for the grandmother to move into the parents' apartment for a period of three months and to monitor the parent's care of PK.

Two days post-discharge, at approximately 0300 hours, the grandmother heard PK crying and took her from the bassinet and brought her to the mother who had been sleeping. The mother indicated that she would breast feed the baby. The grandmother then went back to her bedroom. At approximately 0935 hours, the grandmother awoke and went to the parents' bedroom where she observed PK laying beside her mother in bed. The grandmother noticed that the baby's ear was blue and picked her up and found her to be "stiff" and "cold". She began to administer CPR and the father called 911.

The mother later reported she had placed PK back in the bassinet after the 0300 hours feeding; however she had again breast fed PK around 0500 hours and may have dozed off. The grandmother and mother reported that PK was to be fed every two hours. There was no clock in the bedroom.

- **Cause of Death[6]:** No definitive anatomic or toxicologic cause of death
  Sudden unexpected death in infancy (SUDI)
  - Sleeping in an unsafe sleep environment
    (Bed-sharing with an adult)
- **Manner of Death:** Undetermined

Findings and Recommendations:

The Society Internal Review and subsequent PDRC review identified concerns and made recommendations. These recommendations included:

1. ***The Society should develop best practice guidelines for staff and supervisors conducting assessments/investigations with high risk infants.***

   Guidelines would provide Society staff with a practice framework in working with high risk infants. There was no information in the Internal Child Death Review regarding the Society already having best practice guidelines or a High Risk Infant Protocol.

[6] Under the new classification approach (see page 38), the cause of death would be provided as Undetermined; Contributing Factor Unsafe Sleep Environment (bed sharing with an adult)

2. ***The Society should review with its child protection workers and supervisors the importance of obtaining information from collaterals involved with a family during prenatal involvement as early as possible, to ensure that a comprehensive plan is developed at the time of birth.***

   Information from community professionals to assist with the development of the most appropriate case plan was received at, or around the time of PK's birth. Based upon the information received, the Society concluded that an apprehension plan could no longer be supported and this resulted in an alternate plan that was not fully assessed.

3. ***The Society should ensure that Safety Plans and/or Family Service Agreements that are developed to reduce risk and ensure a child's safety contain detailed information regarding all parties' responsibilities and expectations.***

   The Safety Plan and Family Service Agreement did not specify, in detail, the responsibilities and expectations of the grandmother with respect to her monitoring/supervision role.

Regional Supervising Coroner

4. ***The Regional Supervising Coroner should review with the hospital which cared for PK after her birth, the need for a comprehensive discharge plan when dealing with vulnerable infants. In addition, the importance of nursing staff reviewing the risks of bed-sharing with new parents should be discussed. There is contradictory information as to whether the dangers of bed-sharing were reviewed with the parents.***

   Comprehensive discharge planning between the hospital and all involved parties is critical when dealing with high risk infants. The hospital discharged PK with no notice to the Society to allow them to adequately plan for the discharge. Nursing staff indicated that they had little experience dealing with premature infants and were anxious about discharging a baby with such a low birth weight.

Part 3: Ontario's Children's Aid Societies and the PDRC

Examples of Two Death Reviews

Introduction to Case Review #2

There are occasions during retrospective PDRC reviews, where concerns are identified with systems, decision making, management of cases or the provision of health and/or child protection services to families and children.

At times, children's deaths are found to be preventable, meaning similar situations may be avoidable in the future. It is particularly concerning when a child dies and contributing factors may include the service the child may or may not have received from the child protection system. One case is highlighted where the Committee believed that more collaboration and different decisions might have resulted in different outcomes for the child. The involved agency completed an internal child death review and recognized that changes in service, policy and training were warranted. Occasionally, more intrusive action by a Society is called for in certain circumstances; the child in the following case may have benefited from such intervention.

Review of the Death of KS

Summary of Circumstances Surrounding the Death:
On the day of death, the mother had taken the child (four months old) to the father's home for an unsupervised visit. Prior to the visit the mother and the father argued because the father did not want to take the child for the visit. The child was nonetheless dropped off at the father's home for the day. The father's access visits were supposed to have third party support, but this direction was not followed. The mother later advised the police and the CAS worker that the father kept calling her after she dropped the child off and yelled at her to come and pick up their child as the child was upset.

Later in the day, the mother picked up the child from the father's home and noted that the child was moaning, her eyes were only partially open, and she was limp and pale. The child was taken to hospital and subsequently transferred to a Children's Hospital as a CT scan revealed intracranial bleeding and a possible fracture. The next day, a doctor advised that the child had retinal haemorrhaging and was in critical condition. The child's condition continued to deteriorate and she died two days later.

The father ultimately admitted to shaking his daughter to get her to stop crying. He said that he did not want to be alone with his daughter, but that the mother forced him to be and he had no support. The father was charged with second degree murder. He pled guilty to manslaughter and was sentenced to eight years in prison.

- **Cause of Death:** Hypoxic-ischemic encephalopathy due to head injury
- **Manner of Death:** Homicide

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Findings and Recommendations:

While the family had only a brief period of involvement with a Children's Aid Society, this infant had sustained previous injuries in her four months of life prior to her death. The Society Internal Review and subsequent PDRC review identified the following concerns and recommendations:

1. ***The agency should review with child protection workers and supervisors the basic requirements when conducting a forensic investigation. These include contact with collaterals, medical examination of the child when there are injuries and consultation with police as appropriate. The agency should also review the training needs of workers and supervisors with respect to forensic interviewing skills, supervising forensic interviewing and child development.***

   A comprehensive forensic investigation into the child's previous injuries was not conducted, necessary medical examinations did not occur and no consultation occurred with police. The worker was inexperienced and the plan developed with the supervisor was not sufficient to address the safety concerns. The four month old child had various bruises that could not be explained as being caused by the child's activity level, given her stage of development.

2. ***The agency should develop learning opportunities for staff to increase knowledge in working with families where there are domestic violence concerns or high conflict situations. The training should include education on the inappropriateness of having victims of domestic violence supervise access with the perpetrator of the violence.***

   The mother disclosed incidents of physical violence and verbal aggression. The mother was designated as the third party support person despite the concerns about domestic violence.

3. ***The agency should develop a policy and/or procedure on the process that should be followed when there are stipulations placed on a caregiver's access so that all parties are clear as to what the expectations are. Written correspondence outlining the plan would be beneficial.***

   At the time of the child's death the father was exercising access to the child with the mother as third party support. It is not clear as to whether the agency's position was that the father was not to be unsupervised with the child or if this was based entirely on the father's wish to have third party support. The infant was with the father without support or supervision; the expectations were unclear to the caregivers.

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4. ***The agency should develop, if it does not already exist, a case conference format (such as a Child Abuse Review Team) where cases are reviewed for planning and/or verification purposes. One of the criteria for case presentation should be infants with unexplained injuries.***

   There were multiple concerns with how this case was investigated and managed and having the case presented at an internal planning meeting would have highlighted the concerns with the investigation and may have led to a comprehensive investigation of all the concerns.

5. ***The agency should review with its child protection workers and supervisors the need to ensure that parents who are exercising access to their children have safe sleeping arrangements for their child. Society workers should ensure that in addition to bed sharing they review with parents the dangers regarding infants being placed to sleep in car seats, playpens, swings.***

   While the worker identified unsafe sleeping conditions at the father's home and stopped overnight access visits the father continued to have the child for 12 hour visits without appropriate sleeping arrangements. The child slept in a car seat.

6. ***The Regional Supervising Coroner should hold a Regional Coroner's Review with the [Emergency Room] ER physician and the paediatrician who saw the child with previous injuries, stressing their obligations under the Child and Family Services Act to report suspicious injuries. This review should include the Chief of Staff, the Chief of Emergency, the police and the Children's Aid Society.***

   The Internal Review cites that physicians of record did not always report concerns directly to CAS.

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THEMES from 2011 PDRC Review of CAS Cases

One of the objectives of the PDRC review process is to track themes that emerge over time with a view that identifying such trends may contribute to knowledge that will enhance future service to, and safety of, children who come into contact with the child welfare system. In the 46 deaths reviewed in 2011 with CAS involvement, the following patterns emerged. These themes were consistent with the findings of previous years.

Risk Factors

The PDRC tracked the following risk factors from the cases reviewed in 2011. While not necessarily a risk factor predictive of death, the themes seen by the PDRC are interesting and over time may inform future risk assessments. Please note that all information in the following charts was extracted from the PDRC reports of 2011 and the corresponding Society Internal Death Reviews and may not be all inclusive.

Category of Risk Factor	Definition
Substance Abuse	CAS documented that at least one of the caregivers suffered from substance abuse issues.
Mental Health	CAS documented that at least one of the caregivers suffered from mental health issues.
Physical/Emotional Abuse	It was suspected and/or verified by a CAS on at least one occasion, that the child/children in the family were victims of physical and/or emotional abuse.
3 or more CAS Openings	A CAS had opened a file relating to the caregiver(s) on at least three separate occasions.
3 or more CAS Referrals	A CAS had received at least three separate referrals relating to the caregiver(s) (referrals could have been received during one opening, or during a number of openings).
Neglect/Inadequate Supervision	It was suspected and/or verified by a CAS on at least one occasion, that the child/children in the family were victims of neglect or inadequate supervision.
Sexual Abuse	The CAS had documented a history of sexual abuse within the family (caregivers were themselves victims or perpetrators) and/or the CAS has suspected and/or verified on at least one occasion that the child/children in the family were victims of sexual abuse and/or perpetrators.
Previous Death	The caregiver(s) have experienced a previous death of a child.
Caregiving Capacity	The CAS or PDRC has noted concerns about the caregiver(s) parenting capacity either before or after the death of the child.
Domestic Violence	The CAS has documented that the caregiver(s) had been involved in at least one domestic violence incident, either as victim or perpetrator.
Childhood History with CAS	One or both of the caregivers has had involvement with the CAS as a child.

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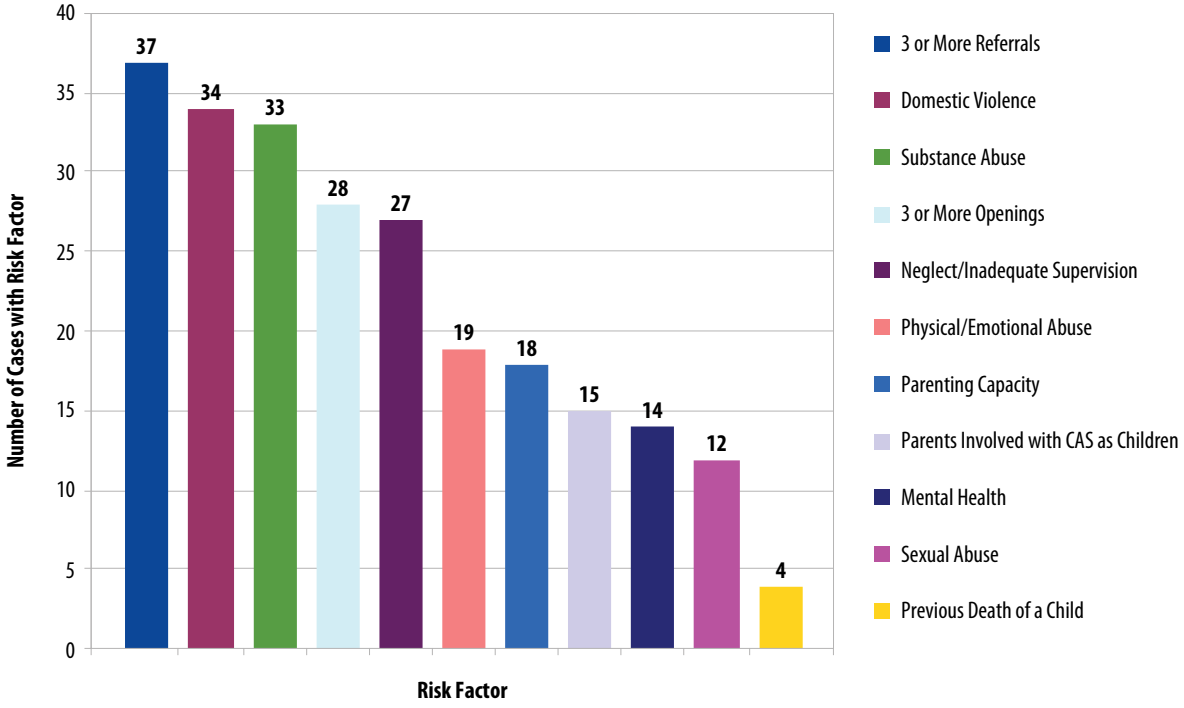
Presence of Risk Factors in 2011 PDRC Case Reviews



Risk factors present most frequently in the 44 (46 children) cases reviewed:

1. 37 families had **three or more referrals** to child welfare = 84%
2. 34 families had experienced **domestic violence** = 77%
3. 33 families had histories or current issues with **substance abuse** = 75%
4. 28 families had **multiple openings** with child welfare (over 3 openings) = 63%
5. 27 families had a verified history of **neglect/supervision** concerns = 61%

A very concerning pattern emerged from our reviews. Substance abuse, domestic violence and three or more referrals to child welfare were three risk factors identified with greater than 75% frequency in the cases reviewed by the PDRC.

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Top 10 Most Frequently Made PDRC Recommendations in 2011

The following chart presents the most frequently recurring recommendations made by the PDRC in the 2011 death reviews.

Recommendation:	Frequency
1. Societies should develop a standard of practice for securing any and all child protection records of clients when held by other societies	**14**

Recommendation details:

- Secure the information and include this knowledge for case planning purposes
- Obtain records for all relevant family members/caregivers of children, including anyone who may live in the home, even if they are not in a 'caregiving' role
- Ensure that when transferring cases internally and to other agencies, the history is also presented
- Incorporate prior child protection investigations, outcomes and risk assessments for all children into case planning
- Train workers to consider family history and patterns, and to incorporate this into the risk assessment

Recommendation:	Frequency
2. Societies should develop safe sleep practices, policies and guidelines	**13**

Recommendation details:

- Review practices and policies on safe sleep, especially when and how intervention should occur (i.e. if unsafe sleep conditions are observed, this should be addressed before leaving the home)
- Safe sleep training should be mandatory for all staff
- Develop safe sleep guidelines and policies in collaboration with other service providers
- Best practice includes workers observing the sleep space of any infant in the family on every visit
- Staff should educate parents/caregivers about safe sleep practices; seek input from educators about how best to ensure caregivers follow safe sleep practices
- Observation and education of safe sleep expectations to caregivers, should be documented in case notes

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Recommendation:	Frequency
3. Societies should enhance service for chronic substance abuse in families	**12**

Recommendation details:

- Ensure that history of drugs/alcohol is considered in overall assessment
- Consider drug/alcohol testing policy and practice
- Provide training on the impact of parental substance abuse on caregiving
- Provide training for staff on how to engage with parents who have substance abuse issues
- Utilize unannounced visits to caregivers known to abuse alcohol or drugs

Recommendation:	Frequency
4. Societies should develop policy and practice guidelines for servicing families of high risk infants	**10**

Recommendation details:

These guidelines should include:

- Specific expectations for conducting assessments and investigations for high risk infants; staff serving high risk infants should have the necessary skills and the ability to thoroughly assess the risk factors
- Expected levels of contact (contact above and beyond what the current standards call for may be required)
- Supervision of high risk infant cases should include a clinical model that requires more formal and frequent contact with staff servicing high risk infants
- The expectation that all caregivers are included in the service plan
- Policies and procedures that should be followed when children continue to be placed in risky sleep situations
- Training for staff on: risk to premature infants, smoking and stress levels of parents
- Especially important in high risk infant files; files should not be closed until results of drug tests are obtained

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Recommendation:	Frequency
5. A full assessment of a parent's capacity to safely provide care to other children should occur, given risk factors identified during the review of a particular death	**9**

Recommendation details:

- From the analyses of some cases, the circumstances surrounding the death raise serious concerns about the safety of surviving and/or future children
- A formal parenting capacity assessment should be considered
- More intrusive intervention may be warranted to protect other children
- The caregiver should be placed on the Child Abuse Register

Recommendation:	Frequency
6. Societies should review and/or develop protocols to enhance more collaborative service and investigations	**9**

Recommendation details:

Examples of protocols recommended include:

- Police (re investigations)
- Hospital (re discharge planning)
- Other service providers (re addictions, mental health, child development)

Recommendation:	Frequency
7. Societies should develop policies and practices as to when to consider case conferencing	**9**

Recommendation details:

Case conferencing instances could include:

- When servicing high risk clients and/or children, and/or there are a number of significant risks
- When servicing families of vulnerable infants (premature infants, medically fragile infants)
- To enhance effectiveness in cases of child neglect
- When there are multiple openings for similar reasons
- When working with uncooperative/unavailable families
- When there are a number of community-based organizations involved with the family
- When there is any injury to an infant, even if there is a plausible explanation

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Recommendation:	Frequency
8. Societies should ensure compliance with the Joint Directive for Reporting and Reviewing Child Deaths	**8**

Recommendation details:

On occasion, an agency does not adhere to the procedures outline in the Joint Directive for reporting and reviewing child deaths such as:

- Meeting deadlines
- Using an External Reviewer
- Level of analysis and information provided could be more thorough

Recommendation:	Frequency
9. Societies should fully investigate all concerns and referrals that are opened	**7**

Recommendation details:

- Interviewing all children and adults involved in the family
- Victims of domestic violence should be interviewed in complete privacy
- Importance of objective, independent conflict-free investigators
- Verification decisions should be documented

Recommendation:	Frequency
10. The Office of the Chief Coroner and Regional Supervising Coroners should ensure completion of:	**7**

Recommendation details:

- Case conferences
- Regional Supervising Coroner Reviews
- Record checks with CASs

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Other recommendations:

Recommendation:	Frequency
Working with families who are resistant to change/hard to engage	6
Organizational philosophy and/or practices regarding non-voluntary intervention with families	6
Ongoing contact with collaterals	5
Suicide prevention	4
Fire Safety and Prevention	4
Early closing of cases when risk factors may still be present	4

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Recommendations to the Ministry of Children and Youth Services

If the PDRC makes suggestions for changes to policy, legislation or the child protection standards, these recommendations are directed toward the Ministry of Children and Youth Services (MCYS). This table outlines the recommendations made in 2011 and includes the frequency with which they were made.

#	Recommendation:	Frequency:
1	The Ministry of Children and Youth Services (MCYS) should take a leadership role in establishing province-wide standards for information sharing between police and CASs in all cases of suspicious child deaths	**3**
2	MCYS should amend the existing child protection standards to require child protection staff to assess for working smoke alarms during the Safety Assessment	**2**
3	MCYS should clarify standard #2 and their subsequent memorandum, making explicit the requirement for child welfare agencies to investigate all child deaths	**2**
4	MCYS should work with the OACAS to incorporate child deaths into the eligibility spectrum	**1**
5	MCYS should amend the age of protection to 18 years	**1**
6	MCYS should set standards and best practice guidelines for vulnerable youth leaving care, and extend Extended Care and Maintenance (ECM) support	**1**
7	In consultation with other ministries and CASs the MCYS should provide literature on farm safety for the child welfare field	**1**

MCYS Monitoring of, and Responding to PDRC Recommendations

The Ministry's Client Services Branch monitors the implementation status of the PDRC recommendations and the action taken by CASs to respond to specific recommendations. Responses to the recommendations are prepared and submitted to the Assistant Deputy Minister on a quarterly basis.

PDRC recommendations directed to the Ministry of Children and Youth Services are reviewed and responded to by the program and policy divisions and reported to the PDRC and subsequently to the public through this annual report.

The Client Services Branch and the Child Welfare Secretariat worked together to provide a response to the recommendations directed to the MCYS during 2011. Drawn from the above table, the 4 most common themes in recommendations to the MCYS were in relation to:

a. ***Information sharing between police and the Children's Aid Societies;***
b. ***Fire safety and prevention;***
c. ***Child death investigations; and***
d. ***Supports for youth as they prepare for independence.***

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Ministry of Children and Youth Services Response to Themes Identified in 2011 PDRC Reviews

Upon review of the 44 cases concerning the deaths of 46 children who had been involved with a Children's Aid Society (CAS) within the 12 months preceding death and presented to the Paediatric Death Review Committee (PDRC) and Deaths under Five Committee (DU5C), five common themes were highlighted by the ministry.

1. Unsafe Sleeping Arrangements

Fifteen of the deaths reviewed by the PDRC in 2011 involved unsafe sleeping arrangements. This is a consistent theme from past reports.

MCYS Response:

- The Ontario Safety Assessment in the Ontario Child Protection Tools Manual (2007) requires consideration of a child's sleeping arrangements (Safety Indicator #8, e.g. adult sharing a bed with an infant or an unsafe crib) when protection staff assess the family's physical living conditions.
- The ministry funds the Ontario Association of Children's Aid Societies (OACAS) to provide the Education Services curricula which includes a training module on Working with Infants at Risk and their Families. This module includes training on the dangers of bed-sharing and the necessity of appropriate sleeping environments for infants.

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2. Accidental Deaths – Fire, Drowning and Other

Eight of the deaths reviewed in seven reports by the PDRC in 2011 were determined to be accidental deaths related to fire (4), drowning (2) and other (2). This is a consistent theme from past reports.

MCYS Response:

- The ministry funds the OACAS to provide the Education Services curricula, which in 2010 – 2011 included funding for OACAS to develop a Fire Safety Resource Guide. OACAS and other stakeholders, including the ministry, Office of the Fire Marshal, Office of the Chief Coroner (OCC) and Children's Aid Society representatives developed the Fire Safety Resource Guide to be used by child welfare professionals. This guide was developed for the purposes of:
  1. Educating and enhancing child welfare professionals' awareness about the risk factors associated with home fires;
  2. Identifying safety and prevention strategies that can be used by families; and
  3. Providing a list of resources that are available to the child welfare professionals and to the families and children they work with.
- Since its release in spring 2011, there has been a steady demand for the resource guide from child welfare professionals and some local fire departments. The OACAS continues to make the resource guide available in both hard copy and on their public website.
- The guide has promoted further collaboration between CASs and local fire departments on fire safety and prevention initiatives.
- The ministry also funds the OACAS to provide the Education Services curricula which includes a module on Working with Infants at Risk and their Families. The module includes training on the issue of safe bathing practices for infants, and how to educate families on preventing accidental drowning.
- In order to prevent future farm related accidents involving children, the OACAS has made a Farming and Rural Safety Checklist available to CASs for use by child welfare professionals.

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3. Youth Suicides

A total of six deaths reviewed by the PDRC in 2011 were youth suicides, two of which were Aboriginal youth from Northern Ontario.

MCYS Response:

- In 2010 the OCC formed a multi-disciplinary review committee to examine youth suicides in Pikangikum First Nation from 2006 - 2008. Their report and the recommendations were released on September 2, 2011. The ministry is currently reviewing this report and recommendations. The OCC has requested that all parties, including the Province, provide their responses to the recommendations by October 1, 2012.
- Some of the recent commitments made by the ministry in supporting initiatives to address issues of adolescent mental health, including Aboriginal suicides in Northern Ontario include:
  - $6.19 million annually to the Ontario Federation of Indian Friendship Centres for the Akwe:go Urban Aboriginal Children's Program and the Wasa-Nabin Urban Aboriginal Youth Program;
  - $155,000 per year for the Nishnawbe Aski Nation Youth Resiliency Program. Girl Power/ Wolf Spirit Warrior is a youth development program which offers programming for boys and girls ages eight to 16 to increase their self-esteem, foster healthy relationships and enhance leadership;
  - Commitment of up to $50,000 to support Dilico Anishinabek Family Care to provide additional supports to students at Dennis Franklin Cromarty School in Thunder Bay;
  - $700,000 for Nishnawbe Aski Nations' (NANs') strategy to address the root causes of a cluster of suicides in Pikangikum First Nation;
  - $470,800 to Payukotayno: James and Hudson Bay Family Services to provide suicide crisis intervention to James Bay First Nations; and
  - $149,000 to Nodin Child and Family Intervention Services for two-community based youth workers for Eabametoong First Nation.
- On June 22, 2011, the government announced *Open Minds, Healthy Minds,* a Comprehensive Mental Health and Addictions Strategy, with the first three years focused on children and youth. New investments started last year and by 2012-14 funding to support the Strategy will grow to $93 million per year.
- Service and supports will focus on three key areas:
  - Providing faster access to high quality services
  - Identifying and intervening early in kids' mental health needs
  - Closing critical service gaps for vulnerable children and youth including Aboriginal children and youth, kids in key transitions, and those in remote communities
- In recognition of the unique needs of Aboriginal children and youth, new supports for mental health services will be provided to support high needs Aboriginal communities. This includes:
  - Resources to hire new Aboriginal Mental Health and Addiction Workers in high needs Aboriginal communities;
  - An Aboriginal Mental Health and Addictions Worker Training Program; and
  - Enhanced and expanded telepsychiatry model to include other mental health services to serve more children and youth in rural, remote and under-served communities.

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4. Information Sharing

Three child death reviews by the PDRC from 2011 included the recommendation that the ministry develop province wide standards, supplementing those that already exist, on the sharing of information arising out of the investigations of suspicious child deaths by the police and CASs.

MCYS Response:

- The ministry is working with the OCC to develop a strategy to improve information sharing between police and Children's Aid Societies during the investigations of suspicious child deaths. As part of this strategy, the ministry and the OCC created an Information Sharing Working Group with representation from relevant stakeholders. The first meeting of the Information Sharing Working Group occurred in June 2012.
- In November 2010, the ministry announced a plan to modernize CAS and ministry information systems through the implementation of a single information system called the Child Protection Information Network (CPIN). The new CPIN system will provide a full range of integrated functionality, including: case management, financial management, document/records management, and reporting. CPIN will be implemented in two stages, with all CASs using the system by 2015.
- CPIN will mean that the information required to make the best decisions for each child receiving services will be accessible in one place and information will be able to be shared electronically between CASs.

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5. Multiple Risk Factors and History of CAS Involvement

Fifteen of the deaths reviewed by the PDRC in 2011 occurred in families with multiple risk factors (i.e. substance use, domestic violence, mental health, neglect, inadequate supervision, etc.) and a history of CAS involvement. In a number of the reviews, the PDRC recommended that CASs conduct a comprehensive review of historical file information and incorporate this into case planning and decision making.

MCYS Response:

- The purpose of the Child Protection Standards in Ontario (2007) is to promote consistently high quality service delivery to children, youth and their families receiving child protection services from CASs in Ontario.
- Standard #1 requires CASs to assess all referrals from the community by conducting internal and provincial record checks, and if the reporter has alleged the child may have suffered or be suffering abuse, a check of the Ontario Child Abuse Register.
  - If the check of the provincial database reveals there has been previous contact between a CAS and the child, any member of the child's family, and/or the alleged perpetrator that may be relevant to the child protection investigation, the information concerning the contact is included in the case record. Similarly, if the check of the Ontario Child Abuse Register reveals a relevant record, the results of the search are to be documented on the case record within three days.
- In addition, Standard #3 requires CASs to develop an investigative plan which takes into consideration a thorough review of all current and historical information known about the family.
- Developing a single information system, the Child Protection Information Network (CPIN), which will provide a full range of integrated functionality, including: case management, financial management, document/records management, and reporting for all CASs in Ontario. The information required to make the best decisions for each child receiving services will be accessible in one place and information will be able to be shared electronically between CASs. CPIN will be implemented in two stages, with all CASs using the system by 2015.

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PDRC Reviews of the Deaths of Aboriginal Children

By Karen Hill, Director of Aboriginal Services, OACAS

The state of Aboriginal people in Canada is regularly the focus of media attention with reports of crisis and tragedies virtually unheard of in a Western country. In September 2011, Chief Teresa Spence of Attawapiskat First Nation issued a state of emergency, as her community faced the prospect of a harsh winter, with many in that community living in substandard shacks and trailers that offered little in the way of protection from the bitter cold. In spite of the attention, and the flurry of activity that was generated by this and other tragic events, very little has changed for Aboriginal people and the communities they live in. In fact, similar issues have been cited as important factors in the deaths of young Aboriginal children reviewed by the Paediatric Death Review Committee (PDRC).

THE ABORIGINAL POPULATION

According to the most recent census, the Aboriginal population in Ontario grew by 28.7% over the census period, a rate 3.5 times greater than the rest of Ontario, and clearly the Aboriginal infant, child and youth (0 – 19) population increased by 20% compared to 1% in the general population. This increase is due to actual population growth, as well as increasing numbers of Aboriginal people identifying themselves as such.

The rate of growth is disproportionate, and so is the rate of involvement with child protection services. In fact, the rates of Aboriginal children in care now outstrip those of the residential schools era, and the "60's scoop". The numbers are worse and the reasons for admission are different; they represent a legacy of interventions which are inappropriate, ineffective and destructive.

Between 2010 and 2011, the Paediatric Death Review Committee investigated 95 deaths of children, of which 22 were reported to be Aboriginal. This represents a total of 23% of cases reviewed. And so, as the overrepresentation exists in the overall population of children in care, this trend also exists in child deaths subject of a PDRC review. While these numbers are alarming they may not necessarily reflect the totality of the population impacted for several reasons including the fact that a large portion of Aboriginal clients are not identified as Aboriginal by mainstream CASs.

COMMON THEMES & PATTERNS

One of the most conspicuous themes in many of the child death reviews was the fact that there were multiple referrals to a child welfare agency. Before being critical of what may be perceived as minimalist response, it is important to understand the **obstacles confronted by agencies** responsible for serving Aboriginal communities.

First, **recruitment and retention** of staff is problematic, which often leaves agencies short-staffed and/or working with incompletely trained and inexperienced personnel.

Second, many agencies **lack the typical institutional supports** usually available to a Children's Aid Society (CAS). For example it is not uncommon that there will be difficulty contacting a Supervisor because telephone and computer access is generally limited in northern remote fly-in communities. Other challenges include, but are not limited to issues with access to a case management system which is often problematic or non-existent, and availability of few if any collateral community support providers. Often such a basic necessity as health care may be quite limited.

Perhaps most challenging to the CAS response is that Aboriginal families tend to be larger with caregivers frequently grappling with **multi-generational trauma** and contributing issues such as addiction, mental health, and poor physical health related to diseases such as diabetes, Fetal Alcohol Spectrum Disorder and others.

Further, **living conditions** in these communities are often horrific so that attention is often diverted to ensuring basic needs such as warmth, clothing, food and shelter. CAS staff may find themselves absorbed into the culture of denial and minimization many Aboriginal people must subscribe to, just to survive.

Next, the **capacity of parents to cope** and make effective judgements may be impaired by addictions, and/or mental health issues, and/or physical limitations such as Fetal Alcohol Spectrum Disorder, but also by the experience of having nowhere to turn for assistance. Why ask for help, when there has never been any available? These capacity issues linked with the severe environmental deprivation such as a lack of clean, fresh water or a sewage system experienced by many parents create disorganized and chaotic family structures which in turn amplifies the risk to vulnerable infants and children. CAS workers can be easily overwhelmed in trying to observe the forest for the trees in these situations.

The **lack of a viable economic base** beyond being elected to Band Council often means politicians are often highly dependent on the income their seat on Council affords. The result is that Band politicians knowingly or unknowingly influence or may interfere in the intervention of workers' efforts to protect children, even when police are involved.

It is critical to understand that while the issues of agency ability to respond, the capacity of parents and families and the lack of an economic base, all of which have contributed to child deaths, are most prominent in remote Northern communities, the **tragedy of deaths of Aboriginal children is not exclusive to the north.** We are also concerned about the existence and/or migration of these tragedies to southern communities. More recent census data also estimates that at least 50% of the Aboriginal population lives off reserve. Of the 22 Aboriginal child deaths reviewed by the PDRC, four of the children were actually associated with southern CASs. These individuals and families often bring with them the patterns and dysfunction they suffered when living in the north, but lack the social support and geographic closeness which can mitigate the risk to children. As conditions in northern Aboriginal communities do not improve or worsen, we could see the numbers migrating south increase, and most alarming perhaps an increase in the death rates of young Aboriginal children increasing.

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CONCLUSION

The situation for Aboriginal children in Ontario is grim. There is an alarming trend of deprivation and neglect of the needs of Aboriginal children that left unchecked will leave them as parents ill-equipped to care for their own children. CAS agencies are often overwhelmed and under-resourced while trying to meet the myriad of needs and crises that Aboriginal families present with. There are few, if any, resources in northern Aboriginal communities to turn to for assistance and conventional social work approaches may not be the answer. There is frequently a need for very practical, hands on support and assistance. Instrumental support such as ensuring basic routines around sleeping, eating and general care of young infants and children are maintained to support the needs of children within their own communities.

Families need to be able to access warm, safe living environments supported by caring, mature community members who can provide the stability and structure individuals need in times of crisis. We must be mindful of the fact that child welfare agencies are working in a broader community context, therefore attention must be focused on enhancing other community supports.

Finally, attention needs to be paid to the helpers and the leaders who have stepped up and are attempting to hold back what amounts to a tsunami threatening these communities. We need to provide regular debriefing and support to these helpers to ensure their capacity to cope and be effective in supporting these families is not diminished.

We know that kids that grow up in their own communities and know who they are emerge stronger. Therefore, attention needs to focus on cultural revitalization within Aboriginal communities.

The opinions and views expressed herein are those of the Ontario Association of Children's Aid Societies and do not necessarily reflect the opinions of the Office of the Chief Coroner

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Demographics on Aboriginal Child Death Reviews 2010-2011

Total PDRC Child Death Reviews:

PDRC Review Year	2010	2011	Total
	49	46	**95**

Total PDRC Aboriginal Child Death Reviews:

PDRC Review Year	2010	2011	Total
	14	8	**22**

Total Aboriginal Child Death Reviews by Region:

Year by Region:	2010	2011	Totals
Northern	13	5	**18**
Toronto	1	2	**3**
Other Southern	0	1	**1**

- Aboriginal Children represent 23% of cases reviewed in the past 2 years
- Aboriginal Children in the North represent 19% of cases reviewed in the past 2 years

NOTE: these data represent only those deaths reviewed by PDRC (child welfare) in 2010 – 2011. These figures arose from cases where the Society has identified the child as Aboriginal/First Nation and therefore may not reflect all children of Aboriginal descent who have been reviewed by the PDRC during this period.

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Youth in Care and Youth Leaving Care

Introduction

The Provincial Advocate for Children and Youth (PACY) held two days of hearings at the Ontario Legislature in 2011. The Youth Leaving Care Hearings took place November 18th and 25th. The final report was released in May 2012 and has a principle key recommendation, followed by six recommendations for immediate change.

Some of the PDRC's independent recommendations to the Ministry of Children and Youth Services arising in 2011 mirror those made by the Youth Leaving Care Hearings. These included:

1. **MCYS should amend the age of protection to 18 years.**
2. **MCYS should set standards and best practice guidelines for vulnerable youth leaving care, and extend Extended Care and Maintenance (ECM) support.**

Independent and simultaneous to the PACY, the PDRC also recognized the vulnerability of these children and youth.

"My Life Book" is the report of the Youth Leaving Care Hearings Team. Amongst some of the statistics reported are:

- The Province of Ontario has 8,300 Crown Wards
- The average annual cost of maintaining a child in foster care is $45,000
- Fully 43% of homeless youth have previous child welfare involvement[7]

The following feature is a personal story of a remarkable young woman who is a former youth in care. In addition, a special article by the Provincial Advocate for Children and Youth written for this annual report is included.

[7] *My Life in Care,* The Youth Leaving Care Hearings Team, pg 33.

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A Personal Story

There Must Be a Better Life in Store for Me

By S. S. a former Youth in Care

I realized at a young age that mine would not be a charmed life. When I was eight, my mother left me with an emotionally and physically negligent father. In the six years that followed I moved at least ten times, staying with family, friends, and relative strangers. I was living with my aunt's family in 1994 when I was told they could no longer "handle me". Not because I was rebellious, disrespectful, or rude, but because I contributed too much dirty laundry. *There must be a better life in store for me*, I thought as I packed up my whole world, yet again - the contents of which fit neatly inside one neon pink duffle bag and a garbage bag. I made the trek across my community, a remote isolated town in coastal Labrador. A classmate had told her parents about my situation and they welcomed me into their home without ever having met me. The Rosewoods (name changed for confidentiality) were loving, kind and immediately made me feel like a part of their family. Finally, I was part of a functional home. I had a lovely warm home, three healthy meals a day, clean running water, a providing father, and a stable, stay-at-home mom.

Unbeknownst to me, social services were informed of my living situation and began the process of legally apprehending me from my parents. Despite my numerous moves, it was still heartbreaking to see that my parents had signed the statement that they were "unfit, unable, or unwilling" to care for me. I became a foster child, a "crown ward", words I had never even heard before. I stayed with the Rosewoods for nearly three and a half wonderful years. When Mr. Rosewood, an RCMP Constable, was transferred to another community, they took me with them. The entire time was not conflict free. I went through a rebellious period, experimenting with alcohol, smoking, sex, struggling with my identity and constantly battling depression. Looking back, I suppose I was at least partially testing the Rosewood's love for me. The concepts of unconditional love and support had previously been lost on me. But love me they did.

Somehow, through it all, I managed to continue believing there was a better life out there. I spent a semester working with a local family physician as part of a cooperative education course. He was an eccentric and passionate man who challenged and inspired me to pursue a career in medicine. My grades were always high. I participated in extracurricular activities and volunteered at every opportunity. But I also suffered through weekly meetings with my parade of ever-changing social workers. I grew tired of talking about the past and my feelings. It seemed so stagnant, so purposeless, to recount the events that led me to foster care again and again. Mainly because I knew one day I would go away to university and leave this life behind, this life I never believed was meant for me. And so I made the treacherous journey through high school, then before I knew it, it was senior year. I developed a great rapport with all my teachers and the guidance counsellor who all helped with my applications to university and nominated me for scholarships. I accepted an offer of admission and a National Scholarship from the University of Western Ontario.

Immediately after graduation in June, I was released from care. I couldn't comprehend what was happening. I distinctly remember asking my social worker, "So, who do I belong to?" I could not

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fathom the possibility that at 17 years old, I was now an independent adult. I was provided a plane ticket to stay with my birth mother and stepfamily for the summer. This, like it had always been, was a toxic environment. My mother, only 15 years my senior, always seemed more of a bullying peer than an authority figure. Then, and to this day, she maintains that she fought for custody. But I will never forget the phone calls begging to come live with her and my sisters, the image of her signature on my notice of apprehension, and my first two years in foster care with absolutely no communication from her. We fought viciously, and often.

On my eighteenth birthday, I arrived in London, Ontario and was immediately overwhelmed. There were more people in my residence than the entire population of my community in Labrador! As a National Scholar, I was lucky to have a support system of academic advisors and faculty members eager to assist me. After my first lecture in calculus I was reduced to tears. I quickly learned that the curriculum of Ontario Academic Credits was far beyond the education I had received in Labrador. Immediately, I went to my academic advisor and voiced my concerns. I was told that I was bright, I would "pick things up", and that it was simply a period of adjustment. I received 46% on my first university exam, a far cry from the marks I had graduated from high school with. I attended every single lecture and had tutors in every subject. Despite this, my marks fell to an overall 70% average. This resulted in a courteous, but blunt letter stating that I did not meet the requirements to renew my scholarship.

This stress had definitely taken a toll on my health. I was prescribed both antidepressants and stimulants. I suffered severe stomach pains, frequent panic attacks and seriously contemplated suicide on several occasions. *There must be a better life in store for me.* Then, like a voice from heaven, I received a call from Ken Dryden* telling me I had been selected as a recipient of his scholarship, given each year to youth in or from care who demonstrate great promise. I endured another tortuous year of calculus, organic chemistry, and cellular biology. By the end of year two, it was obvious that something had to change. I applied to transfer to the School of Nursing and much to my surprise, was accepted.

In September of 2000, I enrolled in the School of Nursing. Immediately, I knew I had found my niche. Long gone were the days of classes that made no sense to me. Finally, I was learning things and applying them to practice. My grades improved, I made new friends, and my days were generally happier. Just when I thought my life was on track, I ran out of money. I still had no understanding of the concept of budgeting. A week went by and I had eaten very little. I was too embarrassed to admit to my upper-middle class friends that I could not afford to buy food. The physician and his partner I had worked with in high school learned of my situation and like fairy godparents, sent me a cheque in the mail. This act of kindness made me realize the support I had behind me. These people believed I was a worthy investment. After that, I sailed through the nursing program. I spent my free time volunteering at an organization that works to inspire children to enter into science-related fields.

My transition from care to the "real world" could and should have been made easier by the system that intends to protect and provide for vulnerable children. Sessions spent painfully recounting memories better left forgotten could have been spent teaching me the life skills required to successfully leave care and function as a healthy adult. I had no idea how to budget money, grocery shop, and manage time or stress. Instead, I was forced to learn all these things while simultaneously adjusting to university life.

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It also would have been valuable to have a consistent mentor, someone who had successfully made the transition from care themselves, who could provide advice and encouragement. Not once, was I ever contacted by the Department of Child and Family Services to check on me after my release from care. I felt abandoned by "the system."

In 2004, I received a Bachelor of Science in Nursing with distinction and was inducted into the International Honour Society of Nursing. I also received the graduating award for my class; an award that honours the student that most exemplifies the core foundations of nursing, knowledge, caring and compassion. I practiced nursing in cardiac surgery, cardiac anaesthesia research and in primary care across northern Ontario and Nunavut. I fulfilled a lifelong dream and travelled to Africa and volunteered at a safe house for abused and abandoned children for six weeks.

Last fall, I was admitted to medical school. I am well into my first year of studies to become a doctor. I am not sure where this path will take me, but I am confident it will lead me to work with at-risk youth in some context. I no longer maintain relationships with my birth parents. This was a long and painful decision, but one I am certain is right for me. I still struggle to develop intimate relationships and trust new people. But finally, I am content. I have a beautiful little home, a supportive core group of friends, and healthy relationships with my amazing and talented siblings as well as my extended family. I am living the life I always imagined I would.

***Ken Dryden Scholarship**

Ken Dryden Scholarships are awarded to select young people, currently or formerly in the care of the Canadian child welfare system, who demonstrate great achievement and promise. Each scholarship covers up to $3,000 or 80% of the cost of tuition and fees, whichever is less, and is renewable annually. (http://www.youthincare.ca)

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Parenting the Province's 8,300 children in care—time for fundamental change

By Irwin Elman, Provincial Advocate for Children and Youth

Ask parents about their dreams for their children, and almost all will say, "I just want them to be happy and healthy." Of course, most parents have aspirations for their children to go on to post-secondary education and become doctors, teachers, electricians or technology wizards. No matter how big or small our ambitions, from their birth, every decision we make reflects our values and priorities and sets in motion the kind of life we want for our children. For better or for worse, most parents work very hard to get it right, or as right as it can ever be. As a society, we expect this.

But what happens if, through no fault of your own, your parents cannot do their job? What happens, if, for your protection, you are removed from your family and brought into the care of a Children's Aid Society? If your family can't be helped to solve the problems, you will remain in care and become one of Ontario's 8,300 Crown Wards.

"Do you know how it feels to have your life typed and filed?"

Kayla, 21, Former Youth in Care

You will be assured that you will be taken care of, protected, nurtured, in a group home, a foster home or some other setting. Soon, however, you will learn the "buts" that define the conditions of your care. *But* only if you follow our plan. *But* only if you make it through until 18. *But* only if you are in school after that. *But* only until you are 21. You may be one of the fortunate young people who lives with a family that treats you as their own. More commonly, you are on the move, to a new placement, new community and new school, toting your worldly possessions with each change. And sometimes, you take matters into your own hands and leave the system, fending for yourself, living on the streets or in shelters, trying to survive on a minimum wage job, or worse.

Recently, supported by the Office of the Provincial Advocate for Children and Youth, the "Province's children" answered that question. On May 14, 2012, they released their report, My REAL Life Book, summarizing the issues presented at the *Youth Leaving Care Hearings* held at Queen's Park in November 2011 (www.provincialadvocate.on.ca).

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Forty-seven years ago, the system said goodbye to Stewart when he aged out of care at the age of 18. Forty-seven years ago, Stewart had not completed high school and did not feel prepared to succeed. He didn't know how to care for himself, let alone make his way in the world, on his own. On the day the Province's children released their report, Stewart met several generations of his extended "care" family. It was a reunion of sorts: although over four decades separated them in age, and they'd never met before, it was as if they had grown up together, because their stories were virtually identical. Those stories revealed the following common themes:

- ***We are vulnerable.***
- ***We are isolated.***
- ***We are left out of our lives.***
- ***No one is really there for us.***
- ***Care is unpredictable.***
- ***Care ends and we struggle.***

Each of these themes is expanded upon in My REAL Life Book and the accompanying video. The young people's personal accounts reflect what the research tells us:

- Youth in care are less likely to earn a high school diploma, pursue higher education or make a living wage.
- Youth in care are more likely to experience economic hardships, be homeless, struggle with mental health challenges and become involved with the criminal justice system once they leave the Province's care.[8]

This is not a new problem. It has been an ongoing, slow-motion tragedy since before my time. Dozens of reports and expert panels have tried to address this, but with little improvement in the overall picture. There is a desire for change and frustration across the system – people have the skills, talents, and ideas to support children and youth in care to succeed. So why aren't we further ahead?

Let's look at just one statistic: 56% of youth in care do not graduate from high school.[9]

If we, the people of Ontario, had clear goals and plans for supporting children and youth in care to succeed, I believe we would parent them very differently than we do now.

[8] Provincial Advocate for Children and Youth. (2012). *25 is the new 21: The Costs and Benefits of Providing Extended Care & Maintenance to Ontario Youth in Care Until Age 25.*

[9] Ontario Association for Children's Aid Societies. (2011). *An Agenda for Children and Youth Pre-Budget Consultation.*

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Through My REAL Life Book, youth in and from care have spelled out THEIR goals and recommendations for what they need to succeed. Their goals:

1. ***We are safe, protected and respected as equal human beings.***
2. ***We have people in our lives who are THERE for us.***
3. ***We have stability and connections to family, roots and culture.***
4. ***We are part of our lives and have a say in what happens to us.***
5. ***We have access to the information, resources and options we need.***
6. ***We are supported throughout care to become successful adults.***
7. ***We are part of a strong and proud community of youth in and from care.***
8. ***That the best experiences for some children and youth in care, become the standard for everyone in care.***[10]

Based on 183 submissions and over 40 presentations at the Hearings, young people are telling us that children and youth need consistent support in their lives. They need people to whom they can turn. They want to stay with their foster families and in their group homes until they are actually ready to leave. In terms of the emotional and financial support that now ends at 21, they say it should be extended to 25. Adam, 27, a former youth in care, stated it clearly: *No other relationship begins with an expiry date.* It seems the Province's children have some shrewd insights and practical solutions.

The Report suggests a number of steps like the call for an extension in care, which can be done "in the meantime." Youth are very clear that "fundamental change" is needed and their "major" recommendation firmly supports this:

- ***The Province should work with young people in and from care and other stakeholders, so that by November 2012 an "Action Plan for Fundamental Change" has been created.***

To quote my son, the Province's children are shouting "Game pause!" They have asked government, child welfare, and all sectors and services that touch their lives, to raise our proverbial heads from the sand — out from the daily work that consumes and sometimes blinds us to what is possible. They have told us that we must overhaul the way in which the Province parents and that transformation must be made together with them.

[10] Report from the Youth Leaving Care Hearings. (2012). *My REAL Life Book*. Office of the Provincial Advocate for Children and Youth.

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In *My REAL Life Book*, youth in care also made these six other recommendations:

- ***Raise the age for Extended Care and Maintenance - "25 is the new 21."***
- ***Allow youth to stay in foster care and group home care until they are prepared for independence.***
- ***Declare "Children and Youth in Care Day."***
- ***Commit to ensuring that every child in care has ongoing health and education services.***
- ***Commit to collecting and publishing information on how children and youth in care are doing.***
- ***Create an online resource for children and youth in and from care.***[11]

We must be ready to make the tough choices and be willing to pay now – or else continue to pay considerably more further down the human development path in the form of other future social costs. If the Province cannot get it right now, its children will continue turning up – not at the front door ready to share their successes, but more likely at the back and side entrances leading to homeless shelters, social assistance, health care facilities and correctional institutions.

We have a rare and remarkable opportunity here. I felt it at the Hearings last November and again, on May 14, when youth in and from care presented their report to the government, via the Minister of Children and Youth Services. Youth in care have realized that they are not alone, that their voices and experiences have the power to transform their own lives.

"I'm here today because I want to tell you that I want a future..." When a youth who is deaf signed this message to us at the Hearings, it was a profound reminder that my job as the Provincial Advocate for Children and Youth is to make sure that his voice gets heard and that his message commands action.

You can't legislate love. You can't institutionalize belonging. Policies can't parent. You can, however, listen, learn and act together with the experts – those who are children and youth in care – and others who have been at their sides. Only then will the Province take its first steps to becoming the parent it should — and can — be.

The opinions and views expressed herein are those of the Provincial Advocate for Children and Youth and do not necessarily reflect the opinions of the Office of the Chief Coroner

[11] Report from the Youth Leaving Care Hearings. (2012). *My REAL Life Book*. Office of the Provincial Advocate for Children and Youth.

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RESEARCH PROJECTS

Abstracts

The Office of the Chief Coroner supports and participates in a variety of research initiatives in order to enhance understanding and public safety in regard to deaths in Ontario. Following are abstracts from research studies related to the deaths of children and youth in which we have been involved over the past year.

A Retrospective Review of Sudden Unexpected Death in Infancy (SUDI) Cases in Ontario 2008-2009: Emphasis on Sleep Environment

Jinnie Kim [1], Karen Bridgman-Acker [2], Albert Lauwers [2]

1 University of Toronto, student School of Medicine, Toronto ON
2 Office of the Chief Coroner, Toronto, ON

Abstract:

Sudden Unexpected Death in Infancy (SUDI) is when a seemingly healthy infant less than one year of age dies suddenly and unexpectedly. After a complete investigation which includes an autopsy, scene investigation, and review of the clinical history, no definitive cause of death is found. Each year, SUDI cases make up approximately 30% of deaths in infants less than one year of age investigated by coroner. This study aims to determine the relative contribution of modifiable and non-modifiable risk factors to SUDI deaths in Ontario in 2008 and 2009 with emphasis on sleep environment. The study is a retrospective chart review of all case files of SUDI deaths investigated by the Office of the Chief Coroner for Ontario (OCC) in 2008 and 2009. Ninety-three (93) cases were analyzed for infant characteristics, parent characteristics, sleep environment, and characteristics of any bed-sharers using a modified chart audit tool developed by the OCC. The data was analyzed using descriptive statistics. The 93 cases of SUDI reviewed in this study accounted for 29% of all deaths of children less than one year of age investigated by a coroner in Ontario, Canada in 2008 and 2009. Unsafe sleep environment was found at the highest frequency in comparison to all of the other variables measured. Out of the 93 cases of SUDI in Ontario in 2008 and 2009, 83 (89%) had unsafe sleep environment as a contributing factor. This finding suggests that perhaps as many as 89% of SUDI deaths may have been preventable. Other variables highlighted in this study include non-modifiable risk factors such as male gender, infant age, prematurity, young maternal age, history of Children's Aid Society involvement; as well as modifiable risk factors such as bottle feeding, parental smoking, alcohol abuse and prescription drug abuse. This study demonstrates that new Canadian data on the risk factors of SUDI is consistent with the literature. There is a lack of Canadian research on SUDI, and especially on bed-sharing. This study will contribute to filling this gap and support the development of public health campaigns in Canada promoting infant safe sleep and reducing the known risk factors for SUDI.

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When a Client Dies - Supporting Child Protection Staff

Sasha Pivarnyik [1], Karen Bridgman-Acker [2]

1 MSW student, University of Windsor, Toronto CAS
2 Office of the Chief Coroner, Toronto, ON

Abstract

This study investigated how child protection workers are affected by client deaths within their agency, and which agency resources (formal or informal) are most helpful in assisting the worker after the death. An anonymous survey was sent to all 52 child protection agencies in Ontario, and a total of 702 participants took part in the survey. Most participants (81.9 %) indicated they had been affected by a client death at one point in their career and the top symptoms reported were increased stress, feeling increased accountability at work, and having recurring thoughts of the death. Participants rated informal colleague support as the most readily available type of support, as well as the most helpful. Overall, participants felt they received emotionally supportive supervision and clear direction from supervisors, and that they feel safe talking about job related stress in various work environments. Respondents did express a need for more assistance with paperwork and other fundamental work tasks, as well as increased referrals for support from their supervisors.

See full article in the OACAS JOURNAL, Spring 2012

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Are Infants Exposed to Methadone In Utero at an Increased Risk for Mortality?

Lauren E Kelly [1, 2], Michael J Rieder [1], Karen Bridgman-Acker [3], Albert Lauwers [3], Parvaz Madadi [4], Gideon Koren [1, 2, 4]

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3 Office of the Chief Coroner of Ontario, Toronto, ON;
4 The Hospital for Sick Children, Division of Clinical Pharmacology and Toxicology, Toronto, ON

ABSTRACT

Background
The prevalence of opioid abuse is increasing in North America. Opioid abuse during pregnancy can cause medical, obstetric and psychosocial complications. Neonates exposed to opioids in utero often develop the neonatal abstinence syndrome. Methadone maintenance therapy is the treatment of choice for maternal opioid dependency. There have been unsupported concerns that infants cared for by mothers treated with methadone have higher mortality rates during the first year of life than in the general population.

Objectives
To compare the mortality rates of infants exposed to methadone in utero to those of general population in Ontario, Canada.

Methods
We utilized several provincial and national databases including those of the Office of the Chief Coroner of Ontario, the Canadian Institute for Health Information, and the Ontario Infant Mortality Rate Report. Reference organ weights were obtained from the peer reviewed literature.

Results
The Office of the Chief Coroner of Ontario has reported 8 deaths in children under one associated with in utero methadone exposure between January 1, 2006 and December 31, 2010. Over the same period there have been a total of 1103 cases of neonatal abstinence syndrome recorded in the province. The mean infant mortality rate in Ontario for children under the age of one year over the same period was 5.2 per 1000 live births. The odds ratio for mortality among children with neonatal abstinence syndrome was not different from that in the general population [OR 1.45 (95% confidence interval 0.471-4.459)] (p=0.56).

Conclusion
The available data do not support the concerns that children under the age of one year, born to mothers on methadone maintenance therapy (MMT) are at an increased risk for mortality.

Key Words: *Methadone, pregnancy, mortality, infant*
See full article: J Popul Ther Clin Pharmacol Vol 19(2):e160-e165; May 1, 2012 e160

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Ms. Lauren E Kelly, M. Sc PhD Candidate, University of Western Ontario; **Dr. Michael J Rieder,** University of Western Ontario; **Parvaz Madadi,** University of Toronto; **Dr. Gideon Koren,** University of Western Ontario
"Are Infants Exposed to Methadone in utero at an Increased Risk for Mortality?"

Ms. S. S. (former youth in care)
Personal Story: "There Must be a Better Life in Store for Me"

Staff at the Ministry of Children and Youth Services
Child Welfare Secretariat and Client Services Branch
Ministry Response to 2011 Themes and Recommendations

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Aboriginal Child Death Reviews

Staff and youth from the Provincial Advocate for Children and Youth
"Parenting the Province's 8300 children in care – time for fundamental change"

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