Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury

We the
undersigned

of *Toronto*

of *Toronto*

of *Toronto*

of *Toronto*

of *Toronto*

the jury serving on the inquest into the death of:

Surname:	Given names:
Anderson	*Diane*

Aged: *35* held at *Toronto, Ontario*

From the *6th April* to the *6th of June* 20 *11*

By Dr. *David H. Evans* Coroner for Ontario

having been duly sworn, have inquired into and determined the following:

1.	Name of deceased	*Diane Anderson*
2.	Date and time of death	*December 22nd, 2007 at 04:00 a.m.*
3.	Place of Death	*Unit 237 303 Grandravine Drive*
4.	Cause of death	*Inhalation of smoke and fire gases*
5.	By what means	*accidental*

The verdict was received on the 6th day of April 20 11

Original signed by Coroner

Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury

We the
undersigned

of *Toronto*

of *Toronto*

of *Toronto*

of *Toronto*

of *Toronto*

the jury serving on the inquest into the death of :

Surname: ***Whittaker*** | ***Jahziah***

Aged: ***3*** held at ***Toronto, Ontario***

From the ***6th of April*** to the ***6th of June*** 20 ***11***

By Dr. ***David H. Evans*** Coroner for Ontario

having been duly sworn, have inquired into and determined the following:

1.	Name of deceased	***Jahziah Whittaker***
2.	Date and time of death	***December 22nd, 2007 at 04:00 a.m.***
3.	Place of Death	***Unit 237 303 Grandravine Drive***
4.	Cause of death	***Inhalation of smoke and fire gases***
5.	By what means	***accidental***

The verdict was received on the day of 20

Original signed by Coroner

Office of
The Chief
Coroner

Bureau du
coroner
en chef

Verdict of Coroner's Jury

We the
undersigned

of ***Toronto***

of ***Toronto***

of ***Toronto***

of ***Toronto***

of ***Toronto***

the jury serving on the inquest into the death of :

Surname: ***Simpson*** | ***Tayjah***

Aged: ***9*** held at ***Toronto, Ontario***

From the ***6th of April*** to the ***6th of June*** 20 ***11***

By Dr. ***David H. Evans*** Coroner for Ontario

having been duly sworn, have inquired into and determined the following:

1.	Name of deceased	***Tayjah Simpson***
2.	Date and time of death	***December 22nd, 2007 at 04:00 a.m.***
3.	Place of Death	***Unit 237 303 Grandravine Drive***
4.	Cause of death	***Inhalation of smoke and fire gases***
5.	By what means	***accidental***

The verdict was received on the day of 20

Original signed by Coroner

RECOMMENDATIONS:

To The Ministry of the Attorney General

1 – It is recommended to The Ministry of the Attorney General that Victim Services of Toronto expand to allow them 5 full time case workers to implement an intensive Case Management Program for vulnerable/at risk victims of crime and tragic circumstances. The Intensive Case Management Program will assess and triage those most at risk to an intensive service whereby a support worker will provide a defined range of services until victims are linked to appropriate support services within the community for a period of time up to one year.

Victims Services will be responsible for conducting regular (i.e. annual) needs assessments of workloads based on population growth, crime statistics, etc.

To Victim Services

2 – It is recommended to Victim Services of Toronto that if they have referred their client to another service, instead of referring a person by providing the client with a phone number, the recommending agency will contact the support agency to investigate wait list length and appropriateness of the referral prior to making the referral.

3 – It is recommended to Victim Services of Toronto that they will follow up with the client/referred agency to make sure that contact has been made. A record should be kept of what referrals are made and what follow up is done. Linkage encourages the appropriate service provider to be identified and engaged. If several agencies are involved with the family/individual the first agency to get the referral will continue to work with the family/individual until the appropriate service provider is identified and engaged.

4 – It is recommended to Victim Services Toronto that they will assist with offering transportation services, tokens, volunteer transport, etc. to clients who can not easily leave the house/community (e.g. depressed, traumatized, parents with children etc.) but require off-site counseling/support.

To the Ministry of Community Safety and Correctional Services (MCSCS)

5 – 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.

6 – It is recommended that the sale of matches and lighters to minors be prohibited and that matches and lighters not be displayed for sale in plain view.

7 – It is recommended that lighters sold in Ontario should be made child proof.

8 – It is recommended to the MCSCS and Ontario Fire Marshal that it be recognized as best practice that smoke alarms should be installed in all sleeping rooms in addition to the current legislation requiring one on very floor.

9 – It is recommended that the Ontario Fire Code be amended to require occupants to notify the owner of nonfunctioning smoke alarms

For example:

> **Immediate Notice to Owner**
>
> An occupant of a dwelling unit shall immediately notify the owner upon discovering a disabled, inoperable, disconnected, or otherwise nonfunctioning smoke alarm in the dwelling unit where that smoke alarm is required to be installed by law.

10 – It is recommended to the Ministry of Community Safety and Correctional Services that the budget of the Office of the Fire Marshal be increased for the sole purpose of broadcasting public service announcements regarding fire safety.

To the Ministry of Children and Youth Services (MCYS)

11 – 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 Marshall's Office develop a protocol to support fire safety education. This education will include the importance of working smoke alarms and of 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 families.

12- It is recommended that the Child and Family Services Act should be amended to require professionals to identify themselves and their relationship to the child(ren) at the time of reporting to a Society pursuant to Section 72. The identity of the professional should not be released to the family without just cause.

13 – It is recommended that the MCYS fund an independently conducted comprehensive workload measurement study of Children's Aid Societies with a commitment to implement feasible recommendations. The study will assess not only the impacts of current legislative requirements and best practice implementation on workload in relation to the delivery of quality service to children and families, but also, the impact and efficiency of current and future single information systems for child Welfare in the Province of Ontario.

14 – It is recommended that MCYS continue to develop and implement a single information system for Child Welfare in Ontario currently known as Child Protection Information Network CPIN. The system will provide all Children's Aid Societies with access to full information of a family's involvement with any child protection agency in Ontario. CPIN shall remain within the care and control of the Province of Ontario. The system should be comprehensive, user friendly, efficient and include a capacity to perform key word searches.

15 – It is recommended to the MCYS that irrespective of the development and implementation of a single information system, The MCYS support and funds a project to electronically image all historical and current paper and micro film case records for all Children's Aid Societies in the province of Ontario

16 – It is recommended that irrespective of the development and implementation of a single information system, The MCYS provide funding for societies to acquire the necessary tools to allow child welfare workers to efficiently take electronic notes in the field and integrate them into current information systems and eventually the single information system.

17 – It is recommended that the Ontario Ministry of Children and Youth Services create a policy or direction clarifying the issue of "consents" (i.e. reciprocal information sharing) and in what circumstances Agencies/Individuals can share confidential information.

18 – It is recommended to the Ministry of Children and Youth Services that when a case worker from a Children's Aid Society is investigating an allegation of abuse against a parent or caregiver, the interview of the child(ren) and youth should occur in a separate physical space away from the parent or caregiver.

19 – It is recommended to the Ministry of Children and Youth Services that all Children's Aid Society workers must review the ORAM/Fast Track information systems prior to contacting a family instead of relying solely on the Screen Intake workers information.

20 – It is recommended to the Ministry of Children and Youth Services that all CAS workers must assess the entire living space of the family (every level, common rooms, sleeping areas, etc.) during the safety/risk assessment of the home.

21 – It is recommended to the Ministry of Children and Youth Services that if a service has to be referred out, instead of referring a person by providing the client with a phone number, the Children's Aid Society will contact the support agency to investigate wait list length and appropriateness of the referral prior to making the referral.

22 – It is recommended to the Ministry of Children and Youth Services that Children's Aid will follow up with the client/referred agency to make sure that contact has been made. A record should be kept of what referrals are made and of what follow up is done. Linkage encourages the appropriate service provider to be identified and engaged. If several agencies are involved with the family/individual the first agency to get the referral will continue to work with the family/individual until the appropriate service provider is identified and engaged.

23 – It is recommended to the Ministry of Children and Youth Services that Children's Aid assist with offering transportation services, tokens, volunteer transport, etc. to clients who can not easily leave the house/community (e.g. depressed, traumatized, parents with children etc.) but require off-site counseling/support

To the Ministry of Education

24 – It is recommended that the Ministry of Education make fire safety education mandatory in the Ontario curriculum. The topic of fire safety and escape planning must be taught once each year from Junior Kindergarten through to and inclusive of grade 8.

25 – It is recommended that high schools add fire safety to eligible volunteer time requirements in high schools. See recommendation number 30 made to The Toronto Fire Services and the Ontario Fire Marshall

26 – It is recommended that the Toronto District School Board must create a policy that if a child whom the family has enrolled in a voluntary program (i.e. junior kindergarten) has experienced a high level of absenteeism, the school social worker should become engaged with the family to determine if there is a barrier to the child's participation.

To the Ministry of Municipal Affairs and Housing

27 – 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.

To the Toronto Community Housing Corporation

28 – It is recommended that TCHC be more participatory in providing tenants with fire safety education (distribution of literature). This should happen in collaboration with the Toronto Fire Service's Fire Safety Education Unit.

29 – It is recommended that the TCHC clearly educate their tenants on the role of their Health Promotion Officers.

To the Toronto Fire Service and the Ontario Fire Marshall

30 – It is recommended that the Ontario Fire Marshall and the Toronto Fire Service work with community agencies to recruit volunteers to create public awareness for neighborhood/home fire safety. The youth in communities would be recruited from the volunteer mandate in Ontario High Schools and among other community sources. The participants would distribute fire safety literature on behalf of the Ontario Fire Marshall and conduct other volunteer/education projects in the community.

31 – It is recommended that The Ontario Fire Marshall collect statistical/demographic information from municipalities and local fire stations in order to evaluate the dissemination of fire safety education from local fire departments.

32 – It is recommended that The Ontario Fire Marshall use existing resources (local fire departments, fire safety literature/materials) in conjunction with local community volunteers and volunteer groups to spread the message of fire prevention/safety. This initiative will be focused on increasing the current 40% compliance of the legal requirement of a fire alarm on each floor of a dwelling to a higher, more acceptable level.

VERDICT EXPLANATION
(Revised August 30th 2011)

Name of Deceased: Diane Anderson, Tayjah Simpson and Jahziah Whittaker
Dates of Inquest: March 24, April 6, 7, 8, 11, 12, 13, 14, 15, 20, 21, 26, 27, 28 and 29, May 16, 17, 18, 19, 27 and June 6, 2011.
Location of Inquest: Coroners Courts, 15 Grosvenor Street, Toronto.

I intend to give a brief Synopsis of the issues presented at this inquest and explain in some detail the reasons for the Jury's recommendations. I would like to stress that much of this will be my own interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to better understand the verdict and the recommendation of the jury and is not intended to replace the jury's verdict.

PARTICIPANTS

Counsel to the Coroner:	Ms. Rebecca Edward Ms. Cynthia Lloyd (Articling Law Student)
Investigating Officer	Det. Larry Reballato 31 Division Toronto Police Service
Coroners Constable	Const. Chris Cornford and Const. J. Murphy Toronto Police Service
Court Reporter	Ms. Ala Kleinberg Network Reporting Suite 3600, 100 King Street West Toronto, ON M5X 1E3

Parties with Standing	Represented by
The Anderson Family	Mr. R. Rowe Suite 500, 1183 Finch Avenue West Toronto, ON M3J 2G2
Toronto Community Housing Corporation	Mr. P. Lukasiewicz Gowlings LLP 100 King Street West Suite 1600 Toronto, ON M5X 1G5

	Ms. O. Raubfogel Toronto Community Housing Corporation 931 Yonge Street Toronto, ON M4W 2H2
The Toronto Children's Aid Society	Ms. L. Hoffbraur and Mr. C. Fitch Toronto Children's Aid Society 30 Isabella Street, Toronto, ON M4Y 1N1
The Children's Aid Workers	Mr. J. Goldblatt and Ms. J Copeland Sacks, Goldblatt Mitchell LLP 20 Dundas Street West, Suite 1100 Toronto, ON M5G 2G8
Toronto City Fire Department	Mr. D. Gourlay Metro Hall 23rd Floor 55 John Street Toronto, ON M5V 3C6
Ontario Fire Marshall	Ms. M. Bacher & Ms. K. Clements Ministry of Community Safety and Correctional Services Legal Branch 77 Grenville Street Toronto, ON M7A 2R9
Toronto District School Board	Ms. W. Lopez Toronto District School Board 5050 Yonge Street Toronto, ON M2N 5N8
The Advocate for Children and Youth	Ms. S. Fraser Law Firm of Suzan E. Fraser Barrister & Solicitor Old Bailey by the Park 112 Adelaide Street East Toronto, ON M5C 1K9
Victims Services Toronto	Mr. David Butt 205 Richmond Street West Suite 501 Toronto, ON M5V 1V3

SUMMARY OF THE CIRCUMSTANCES OF THE DEATH

Ms. Anderson was a 35 year-old single mother of five children who along with her 9 year-old daughter and 3 year-old son died in a fire at their Toronto Community Town House at unit 237, 303 Grandravine Drive in northwest Toronto the early morning hours of December 22, 2007.

Ms. Anderson had been a resident of the Grandravine Toronto Community Housing Corporation Complex for about 12 years with her children who were, 16, 12, 9, 5 and 3 years old at the time of her death. She had left school during grade 9 and had an on-and-off relationship with the father of her two eldest children. She had another child by another man after her relationship with the father of her of her two eldest broke up for a period of time. She then had another child by the father of her two eldest, after which, their relationship ended. In 2004, Ms. Anderson was involved with the father of one of her children and they planned to get married in September 2005. At the end of July in 2005, her then fiancé, was the victim of a shooting homicide at his residence, which was witnessed by one of Ms. Anderson's children. Ms. Anderson was greatly affected by his death, and the child she was pregnant with at the time, was a premature stillborn girl and was delivered the day of her fiancé's funeral. The death of her fiancé affected her mental status and caused her drinking to significantly increase and she was using illegal drugs.

Ms. Anderson had a number of contacts with the Children's Aid Society of Toronto starting in February 2005, following a referral by the police because of a domestic dispute with her fiancé. The referral does not appear to have been of any benefit to the family in anyway as the files were closed fairly quickly after minimal investigation. The Toronto District School Board was involved with the child who witnessed the shooting death of Ms. Anderson's fiancé in July 2005 and arranged for bereavement counselling for the child for some months after the event.

The School also reported a possible case of abuse on another child to the Children's Aid Society in November 2007, just prior to the fire deaths. This was one of the five contacts the family had with the Children's Aid Society.

On December 21, 2007, Ms. Anderson had been drinking alcohol all day and had fallen asleep in her sofa chair where she usually slept after her fiancé was killed. In the early hours of December 22nd, two of her younger children were playing next to her on a Futon and, either on or under the futon, they ignited a paper fire using their mother's lighter. The futon was soon ablaze and one of the children went upstairs to wake the eldest child who came downstairs and found the living room where her mother was sleeping, engulfed in flames. She tried to get the children out of the fire, but the smoke was very heavy and she was forced to leave the residence. The eldest child tried a number of times to re-enter the house to rescue the children, but was unable to do so. She noted the smoke alarms were not activated. She then went to a neighbour who came to help and was able to find two of the younger children and bring them out of the burning house. Ms. Anderson and two of her children, Tayjah Simpson aged 9 and Jahziah Whittaker aged 3, died in the fire.

During the fire investigation two smoke alarms were found near an upstairs closet and the status of the wiring of the junction boxes suggested the alarms were not connected to the electrical power.

The Jury heard from 37 witnesses over the 21-day inquest and 43 exhibits were tendered in evidence. The Jury deliberated for 3 days to reach its verdict.

VERDICT OF THE CORONER'S JURY

Name of Deceased:	Diane Anderson
Date and Time of Death:	December 22, 2007 at 0400 hrs
Place of Death:	Unit 237, 303 Grandravine Drive Toronto
Cause of Death:	Inhalation of Smoke and Fire gases
By what means:	Accident

Name of Deceased:	Tayjah Simpson
Date and Time of Death:	December 22, 2007 at 0400 hrs
Place of Death:	Unit 237, 303 Grandravine Drive Toronto
Cause of Death:	Inhalation of Smoke and Fire gases
By what means:	Accident

Name of Deceased:	Jahziah Whittaker
Date and Time of Death:	December 22, 2007 at 0400 hrs
Place of Death:	Unit 237, 303 Grandravine Drive Toronto
Cause of Death:	Inhalation of Smoke and Fire gases
By what means:	Accident

THE JURY'S RECOMMENDATIONS

These recommendations are not necessarily in order of priority.

To The Ministry of the Attorney General

1. It is recommended to The Ministry of the Attorney General that Victim Services of Toronto expand to allow them 5 full time caseworkers to implement an intensive Case Management Program for vulnerable/at risk victims of crime and tragic circumstances. The Intensive Case Management Program will assess and triage those most at risk to an intensive service whereby a support worker will provide a defined range of services until victims are linked to appropriate support services within the community for a period of time up to one year.

Victims Services will be responsible for conducting regular (i.e. annual) needs assessments of workloads based on population growth, crime statistics, etc.

To Victim Services

2. It is recommended to Victim Services of Toronto that if they have referred their client to another service, instead of referring a person by providing the client with a phone number, the recommending agency will contact the support agency to investigate wait list length and appropriateness of the referral prior to making the referral.

3. It is recommended to Victim Services of Toronto that they will follow up with the client/referred agency to make sure that contact has been made. A record should be kept of what referrals are made and what follow up is done. Linkage encourages the appropriate service provider to be identified and engaged. If several agencies are involved with the family/individual the first agency to get the referral will continue to work with the family/individual until the appropriate service provider is identified and engaged.

4. It is recommended to Victim Services Toronto that they will assist with offering transportation services, tokens, volunteer transport, etc. to clients who can not easily leave the house/community (e.g. depressed, traumatized, parents with children etc.) but require off-site counseling/support.

Coroners Comment:

Evidence was heard that Toronto Victim Services has only two paid crisis counselors on duty at any given point in time and relies on a large number of volunteers to perform their service to all of the City of Toronto. If Victim's Services had more full time staff they could provide a gatekeeper role to provide better service and follow up with their clients to help them through their crisis situation and be sure the clients are linked to the appropriate agency to provide long-term assistance.

To the Ministry of Community Safety and Correctional Services

5. 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.

Coroners Comment:

There is no such requirement in the Fire Code for owners/landlords to test smoke alarms at any time.

6. It is recommended that the sale of matches and lighters to minors be prohibited and that matches and lighters not be displayed for sale in plain view.

7. It is recommended that lighters sold in Ontario should be made child proof.

Coroners Comment

This fire was set by two small children playing with their mother's lighter, as her smoking materials were not out of reach of the children. If the lighter had been childproof the fire might have been prevented.

8. It is recommended to the Ministry of Community Safety and Correctional Services and Ontario Fire Marshal that it be recognized as best practice that smoke alarms should be installed in all sleeping rooms in addition to the current legislation requiring one on very floor.

Coroners Comment:

The present code requires a smoke alarm on all floors only outside the bedrooms. With an alarm in all sleeping rooms, all the residents will be awakened by the alarms sooner and have more time to exit using their escape plan.

9. It is recommended that the Ontario Fire Code be amended to require occupants to notify the owner of nonfunctioning smoke alarms For example:

Immediate Notice to Owner

An occupant of a dwelling unit shall immediately notify the owner upon discovering a disabled, inoperable, disconnected, or otherwise nonfunctioning smoke alarm in the dwelling unit where that smoke alarm is required to be installed by law.

Coroners Comment:

There appears to be no onus on the occupant of the residence to notify the owner/landlord if a smoke alarm is non-functional for whatever reason.

10. It is recommended to the Ministry of Community Safety and Correctional Services that the budget of the Office of the Fire Marshal be increased for the sole purpose of broadcasting public service announcements regarding fire safety.

To the Ministry of Children and Youth Services

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

Coroners Comment:

At present there is no fire safety component to the Safety Assessment Tool used by Children's Aid Societies when dealing with a child with an open file, but still living with their parents.

12. It is recommended that the Child and Family Services Act should be amended to require professionals to identify themselves and their relationship to the child(ren) at the time of reporting to a Society pursuant to Section 72. The identity of the professional should not be released to the family without just cause.

Coroners Comment:

Evidence was heard that in this case the teacher who reported the possible abuse concerns did it anonymously and did not identify herself to the Children's Aid caseworker who attended the school as part of the investigation. The worker indicated if he had known who had reported the case he could have found more information about the child.

13. It is recommended that the Ministry Of Child And Youth Services fund an independently conducted comprehensive workload measurement study of Children's Aid Societies with a commitment to implement feasible recommendations. The study will assess not only the impacts of current legislative requirements and best practice implementation on workload in relation to the delivery of quality service to children and families, but also, the impact and efficiency of current and future single information systems for child Welfare in the Province of Ontario.

Coroners Comment:

Evidence was heard that the individual caseload of the investigative caseworkers appears to prevent timely follow-up of clients or instigation of non-crisis reports. Such a study could lead to improved processing of investigation.

14. It is recommended that Ministry Of Child And Youth Services continue to develop and implement a single information system for Child Welfare in Ontario currently known as Child Protection Information Network. The system will provide all Children's Aid Societies with access to full information of a family's involvement with any child protection agency in Ontario. Child Protection Information Network shall remain within the care and control of the Province of Ontario. The system should be comprehensive, user friendly, efficient and include a capacity to perform key word searches.

15. It is recommended to the Ministry Of Child And Youth Services that irrespective of the development and implementation of a single information system, The Ministry Of Child And Youth Services support and funds a project to electronically image all historical and current paper and micro film case records for all Children's Aid Societies in the province of Ontario

16. It is recommended that irrespective of the development and implementation of a single information system, The Ministry Of Child And Youth Services provide funding for societies to acquire the necessary tools to allow child welfare workers to efficiently take electronic notes in the field and integrate them into current information systems and eventually the single information system.

Coroners Comment:

Evidence was heard that at present all Children's Aid Societies keep their own records and do not always share them with other societies when asked or are taking a long time to provide the information or enter it into the Child Protection Information Network. Current and up-to-date information would help any Children's Aid Society investigating a family, who has received services from another Ontario Children's Aid Society, to acquire the full information on the family's involvement with any previous Children's Aid Society.

17. It is recommended that the Ontario Ministry of Children and Youth Services create a policy or direction clarifying the issue of "consents" (i.e. reciprocal information sharing) and in what circumstances Agencies/Individuals can share confidential information.

Coroners Comment:

Evidence was heard of the confusion over consent for the Children's Aid Societies to acquire information from other agencies professionals/individuals regarding the child(ren) and the Societies' ability to share information with those agencies/professionals/individuals. This needs to be more clearly defined.

18. It is recommended to the Ministry of Children and Youth Services that when a case worker from a Children's Aid Society is investigating an allegation of abuse against a parent or caregiver, the interview of the child(ren) and youth should occur in a separate physical space away from the parent or caregiver.

Coroners Comment:

Evidence was heard that the caseworker investigating the possible abuse report talked to the younger children in the presence of their mother. This was a concern for the Provincial Advocate for Children and Youth as the children could be intimidated by the presence of their care giver.

19. It is recommended to the Ministry of Children and Youth Services that all Children's Aid Society workers must review the Ontario Risk Assessment model/Fast Track information systems prior to contacting a family instead of relying solely on the Screen Intake worker's information.

Coroners Comment:

Evidence was heard that the investigative workers were relying solely on the screen intake worker to do any computer searching of the family before contacting the family.

20. It is recommended to the Ministry of Children and Youth Services that all Children's Aid Society workers must assess the entire living space of the family (every level, common rooms, sleeping areas, etc.) during the safety/risk assessment of the home.

Coroners Comment:

Evidence was heard that the caseworkers do not routinely inspect the whole residence to have an idea of the standard of care the children have or if they are in an overcrowded situation.

21. It is recommended to the Ministry of Children and Youth Services that if a service has to be referred out, instead of referring a person by providing the client with a phone number, the Children's Aid Society will contact the support agency to investigate wait list length and appropriateness of the referral prior to making the referral.

22. It is recommended to the Ministry of Children and Youth Services that Children's Aid will follow up with the client/referred agency to make sure that contact has been made. A record should be kept of what referrals are made and of what follow up is done. Linkage encourages the appropriate service provider to be identified and engaged. If several agencies are involved with the family/individual the first agency to get the referral will continue to work with the family/individual until the appropriate service provider is identified and engaged.

Coroners Comment:

Evidence was heard that the referral to other support agencies by the Children's Aid Society of Toronto was to provide a phone number and the individual was responsible for contacting the agency/counseling service to arrange an appointment. There was no help if the waiting list at the agency was too long or if it was too far

away. There were concerns about workers not knowing what facilities were available in the community for the client.

23. It is recommended to the Ministry of Children and Youth Services that Children's Aid assist with offering transportation services, tokens, volunteer transport, etc. to clients who can not easily leave the house/community (e.g. depressed, traumatized, parents with children etc.) but require off-site counseling/support.

Coroners Comment:

Evidence was heard that there was no effort made to assist Ms. Anderson to get to her counselling by assisting her to travel to the counselling service which was some way away and/or helping her with child care for her to go on her own.

To the Ministry of Education

24. It is recommended that the Ministry of Education make fire safety education mandatory in the Ontario curriculum. The topic of fire safety and escape planning must be taught once each year from Junior Kindergarten through to and inclusive of grade 8.

Coroners Comment:

Evidence was heard from the 16 year-old daughter of Ms. Anderson that she did remember some of the fire safety training she had received in grade school and thought that it would be helpful to repeat that training in High School.

25. It is recommended that high schools add fire safety to eligible volunteer time requirements in high schools. See recommendation number 30 made to The Toronto Fire Services and the Ontario Fire Marshall

Coroners Comment:

This is an addition to the fire safety training to get the youth involved with the community to remind people of the need for fire safety.

26. It is recommended that the Toronto District School Board must create a policy that if a child whom the family has enrolled in a voluntary program (i.e. junior kindergarten) has experienced a high level of absenteeism, the school social worker should become engaged with the family to determine if there is a barrier to the child's participation.

Coroners Comment:

Evidence was heard that the child in the voluntary Junior Kindergarten had a significant amount of absenteeism, but the reasons were not explored because it was voluntary.

To the Ministry of Municipal Affairs and Housing

27. 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.

Coroners Comment:

Evidence was heard that if the unit in question had sprinklers the fire would not have reached flashover and would most likely have been extinguished. The retrofitting of older buildings is not a feasible option due to cost.

To the Toronto Community Housing Corporation

28. It is recommended that Toronto Community Housing Corporation be more participatory in providing tenants with fire safety education (distribution of literature). This should happen in collaboration with the Toronto Fire Service's Fire Safety Education Unit.

29. It is recommended that the Toronto Community Housing Corporation clearly educate their tenants on the role of their Health Promotion Officers.

Coroners Comment:

Evidence was heard that the Health Promotion Officer looked at the Toronto Community Housing Complex's communal health, but could assist individual tenants obtain assistance from other agencies. However, it appeared it was not well known in the housing complex.

To the Toronto Fire Service and the Ontario Fire Marshal

30. It is recommended that the Ontario Fire Marshal and the Toronto Fire Service work with community agencies to recruit volunteers to create public awareness for neighborhood/home fire safety. The youth in communities would be recruited from the volunteer mandate in Ontario High Schools and among other community sources. The participants would distribute fire safety literature on behalf of the Ontario Fire Marshall and conduct other volunteer/education projects in the community.

Coroners Comment:

This is a continuation of recommendation 25 to help the youth in the community spread the information about fire safety to the community.

31. It is recommended that The Ontario Fire Marshal collect statistical/demographic information from municipalities and local fire stations in order to evaluate the dissemination of fire safety education from local fire departments.

Coroners Comment:

This is a means of assessing the community's response to the delivery of fire safety information by the volunteers and if it has improved.

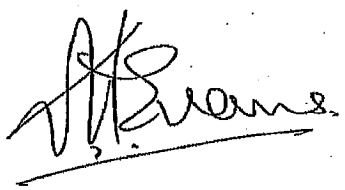
32. It is recommended that The Ontario Fire Marshal use existing resources (local fire departments, fire safety literature/materials) in conjunction with local community volunteers and volunteer groups to spread the message of fire prevention/safety. This initiative will be focused on increasing the current 40% compliance of the legal requirement of a fire alarm on each floor of a dwelling to a higher, more acceptable level.

Coroners Comment:

Evidence indicated that there is only a 40% compliance with the legal requirement to have smoke alarms on each floor in a residential dwelling.

Closing Comment:

In concluding this explanation I would stress again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury's verdict. The comments regarding the evidence are my personal recollection of the same and are not put forward as actual evidence. If any party feels that there has been a gross error in my recollection of the evidence or a conclusion of the jury, I would appreciate that the error is brought to my attention for any corrections to be made by myself.



David H. Evans, M.B., B.S., FRCSC
Presiding Coroner
Toronto
August 30th, 2011