MEMORANDUM OF UNDERSTANDING FOR DISCLOSURE OF CHILD WELFARE REPORTS OF THE PAEDIATRIC DEATH REVIEW COMMITTEE BETWEEN THE OFFICE OF THE CHIEF CORONER AND THE OFFICE OF THE PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH

A. INTRODUCTION

The Office of the Chief Coroner (OCC) conducts death investigations pursuant to the *Coroners Act*. The purposes of the death investigations are described in subsection 15(1) of the *Act*:

Coroner's investigation

15. (1) Where a coroner is informed that there is in his or her jurisdiction the body of a person and that there is reason to believe that the person died in any of the circumstances mentioned in section 10, the coroner shall issue a warrant to take possession of the body and shall examine the body and make such investigation as, in the opinion of the coroner, is necessary in the public interest to enable the coroner,

(a) to determine the answers to the questions set out in subsection 31 (1);

(b) to determine whether or not an inquest is necessary; and

(c) to collect and analyze information about the death in order to prevent further deaths in similar circumstances. 2009, c. 15, s. 7 (1).

In addition, the Office of the Chief Coroner has expert committees which operate pursuant to section 15.4 of the *Act*;

Expert assistance

(4) Subject to the approval of the Chief Coroner, a coroner may obtain assistance or retain expert services for all or any part of his or her investigation or inquest. R.S.O. 1990, c. 37, s. 15 (4).

The Paediatric Death Review Committee (PDRC) retains child welfare experts to assist with review of the circumstances of deaths of children when services were being provided, or had been provided, within the previous 12 months to a child and/or family by a Children's Aid Society under the authority of the *Child and Family Services Act*. An agreement between the Office of the Chief Coroner and the Ministry of Children and Youth Services (MCYS) was established in March 2006 and is known as the Joint Directive (Appendix A). The Joint Directive provides that a quality review of the services which were provided by a Children's Aid Society (CAS) to a child and/or family are critically assessed with a view to understanding where there are potential opportunities for the CAS, Ministry of Children and Youth Services, and others to improve client services. The written reports (the "child welfare PDRC reports") are provided to the CAS and the MCYS by the PDRC. The child welfare PDRC reports contain highly personal and confidential information, often of a medical nature. The PDRC also reviews other deaths including ones where there are complex medical issues or family concerns.

The OCC has a mandate to promote public safety, patient safety, injury and death prevention while promoting health and contributing to the administration of justice.

The *Provincial Advocate for Children and Youth Act, 2007,* provides for advocacy services to be delivered to children and youth by an Independent Officer of the Legislature. This is described in section 1 of the *Act*:

Purpose

1. The purpose of this *Act* is to provide for the Provincial Advocate for Children and Youth (PACY) as an independent officer of the Legislature to,

   (a) provide an independent voice for children and youth, including First Nations children and youth and children with special needs, by partnering with them to bring issues forward;

   (b) encourage communication and understanding between children and families and those who provide them with services; and

   (c) educate children, youth and their caregivers regarding the rights of children and youth. 2007, c. 9, s. 1.

The Office of the Chief Coroner recognizes the important role of the PACY in promoting the well being of children, and believes that the sharing of information generated from the PDRC child welfare case reviews to the PACY by the OCC would promote the advocacy of children and youth, and ultimately, their health and well being.

As such, both parties are committed to developing protocols for information sharing.

Accessing and disclosing information will be conducted in a cooperative manner that is respectful of the role each party plays in supporting children and youth. This includes operating within the legislative requirements for accessing, using and disclosing personal information that govern both parties. However, this agreement provides for an opportunity to share information which has been redacted of personal identifiers, for the purpose of allowing the Provincial Advocate for Children and Youth to better understand the individual and systemic issues that may arise as a product of delivery of service in the child welfare system.

B. PURPOSE

This information-sharing protocol provides a framework for the OCC to provide access to and disclosure of information to the PACY.

The OCC will consider all requests for information that are made in relation to the PACY's duties and mandate.

This agreement describes how redacted child welfare PDRC reports will be requested and provided to the PACY. As well, it will set out the process for requesting reports which contain personal information and for requesting PDRC reports which are not child welfare PDRC reports but where the issues raised in the death of the child relate to the mandate of the PACY.

The OCC understands that the PACY's request for information is not limited to PDRC reports and this agreement does not preclude or prejudice further discussions around those issues.

C. LEGISLATION

Provisions exist within the *Coroners Act* that permit the release of information to the PACY. These include the following sections:

Chief Coroner and duties

4. (1) The Lieutenant Governor in Council may appoint a coroner to be Chief Coroner for Ontario who shall,

(d) bring the findings and recommendations of coroners' investigations and coroners' juries to the attention of appropriate persons, agencies and ministries of government;

Disclosure to the public

18.(3) The Chief Coroner shall bring the findings and recommendations of a coroner's investigation, which may include personal information as defined in the Freedom of Information and Protection of Privacy Act, to the attention of the public, or any segment of the public, if the Chief Coroner reasonably believes that it is necessary in the interests of public safety to do so. 2009, c. 15, s. 10.

The OCC believes that there is no prohibition to releasing the child welfare PDRC reports to the PACY with the proviso that all personal identifying information has been redacted. Where personal information has not been redacted, the Chief Coroner may only release information where he/she believes that it is in the interests of public safety to do so.

The OCC recognizes that it is conceivable that other cases before the PDRC could relate to the mandate of the PACY and is prepared to consider requests about those deaths on a case by case basis. The same process and considerations as set out in the above paragraph would apply.

In all other circumstances, the OCC is governed by the rules set out in *Freedom of Information and Protection of Privacy Act* (FIPPA) for the collection, use and disclosure of personal information. FIPPA prohibits the disclosure of personal information except in limited circumstances.

D. ACCESS AND DISCLOSURE OF WRITTEN INFORMATION

In all cases, the PACY will:

a. Identify the information sought as related to the mandate of the PACY.
b. Complete the "Request Form" (Appendix B).

When seeking redacted information the PACY will:

Provide a written request (electronic or paper version) to the OCC, attention Chair of the Paediatric Death Review Committee (the Chair). The Chair will provide the report where appropriate within 10 days of the OCC's receipt of the request, or as soon as possible thereafter. Where delays are contemplated, the OCC will communicate with the PACY and provide an expected time for delivery.

When seeking full unredacted PDRC reports the PACY will:

Provide a written request (electronic or paper version) to the Ministry of Community Safety and Correctional Services' Freedom of Information and Protection of Privacy Unit which will process the request.

Ministry of Community Safety and Correctional Services
Freedom of Information and Privacy Office
200 First Avenue West
North Bay, ON
P1B 9M3
Telephone: 705-494-3080

Attention: Ms. Marlene Gillis

Marlene.Gillis@ontario.ca

705-494-3077

E. RESOLUTION OF ISSUES

If a dispute arises between any of the parties regarding the interpretation, application or administration of this Memorandum of Understanding (MOU), the parties agree to meet at the earliest available opportunity to discuss the dispute and use their best efforts to come to a resolution.

F. TERMINATION

Either party may terminate this MOU on written notice to the other.

G. EFFECT

It is understood by the parties that this MOU is an expression of the parties' mutual intent and is executed as a matter of convenience to ensure that their practices and procedures are consistent and compatible.

While the parties intend to cooperate fully with respect to the subject matter hereof, the parties may withdraw from this agreement upon written notice to the other party. This MOU does not affect, amend, limit, increase or in any other way change, any legal duties, powers or obligations of the parties.

H. PROTOCOL REVIEW

The OCC and the PACY mutually commit to review the terms of this protocol periodically as required, upon request of either party.

Signed on behalf of the Office of the Chief Coroner

this 9th day of January 2012, by:

Dr. Andrew McCallum

Chief Coroner for Ontario

Signed on behalf of the Office of the Provincial Advocate for Children and Youth

this 16 day of January 2012, by:

Mr. Irwin Elman

Provincial Advocate for Children and Youth

Ministry of Children and Youth Services
Ministry of Community and Social Services
Office of the Chief Coroner for the Province of Ontario

JOINT DIRECTIVE: **Child Death Reporting and Review**
EFFECTIVE DATE: **March 31, 2006**

INTRODUCTION:
This Directive is issued under section 20.1 of the *Child and Family Services Act* and replaces the October 1, 2000 Joint Directive on Child Death Reporting and Review. The first and foremost function of a Society under the *Child and Family Services Act* is to protect children. As a result, when any child dies who was receiving service from a Society at the time of his or her death or at any time in the 12 months immediately prior to his or her death, there are extensive reporting requirements. In addition, when the child dies under questionable circumstances and/or as a result of abuse, mistreatment or parental negligence/neglect, the Ministry of Children and Youth Services requires the Society to conduct a full review of the case. On an exceptional basis, the Society, in consultation with the Ministry of Children and Youth Services and the Office of the Chief Coroner, will conduct a review of other cases. In addition, the Office of the Chief Coroner's Paediatric Death Review Committee may review other cases as appropriate.

This Directive is the result of a comprehensive review conducted by the Ontario Ministry of Children and Youth Services; the Office of the Chief Coroner for the Province of Ontario and the Ontario Association of Children's Aid Societies regarding existing procedures for child death reporting and review. While each system has unique roles and responsibilities, this Directive demonstrates a mutual commitment to cross-sector co-ordination and collaboration. The Office of the Chief Coroner continues to be available on an ongoing basis to Societies and the Ministry of Children and Youth Services for consultation.

This Directive supplements the ministry's Serious Occurrence Reporting Procedures which include the requirement to report all deaths of clients that occur while participating in a service and the ministry's Enhanced Serious Occurrence Reporting Procedures which are to be followed when a significant incident results in the involvement of emergency services and/or where there is, or is likely to be, significant public or media attention.

Effective immediately, the Office of the Chief Coroner has lead responsibility for the analysis of child death, the dissemination of findings and recommendations related to child death and the production of an Annual Report on child death in Ontario. Mechanisms have been established within the ministry and in coordination with the Office of the Chief Coroner to ensure that relevant recommendations inform ministry policy development on a timely and ongoing basis.

The Annual Report will be the subject of review and consultation at an annual forum on child deaths to be undertaken by the ministry and the Office of the Chief Coroner, with the participation of Societies through the Ontario Association of Children's Aid Societies and the Association of Native Child and Family Services Agencies in Ontario. A public report card on child deaths will be established and released jointly by the ministry and the Office of the Chief Coroner.

NOTES AND DEFINITIONS:

This Directive describes requirements that apply when:

(A) A child who was receiving service from a Society at the time of their death, dies, or

(B) A child who received service from a Society at any time in the 12 months prior to their death dies.

For the purposes of this Directive, a "child who received service from a Society" is a child who is receiving or received service directly from the Society, and/or a child who is receiving service indirectly through services provided to his or her family.

In all cases where information from the Society's initial notification or preliminary inquiry suggests that some form of immediate action by the ministry or the Society is necessary, such action should not be delayed pending the outcome of any review.

In Ontario, the coroner classifies deaths into five categories as follows:

1. Natural: Death that is due to a natural disease, or a complication of a disease, or its treatment.

2. Accidental: Death that is due to an occurrence, incident or event that happens without foresight or expectation.

3. Homicide: Death that is due to the action of one human being killing another human being.

4. Suicide: Death that is due to an intentional act of a person knowing the probable consequence of what he/she is about to do.

5. Undetermined: Inadequate evidence for classification; equal evidence, or a significant contest for two or more classifications; suicide which does not meet higher standard of proof.

For the purposes of this Directive, cases will be considered questionable as follows:

Death Classification	Cases To Be Considered Questionable
Natural	• All cases (in care, at home or open) if there are any grounds to suspect that the death was contributed to or linked to an act of omission or commission on the part of caregiver
Accident Homicide Suicide	• All cases where the child was in care • All other cases (open or closed) if the circumstances surrounding the child's death relate in any way to the reasons for service and or Society involvement
Undetermined	• All cases

REQUIREMENTS:

1. The Society will notify the local coroner and the ministry's Regional Office immediately whenever they have knowledge that: (A) a child who received service from the Society up to the time of his or her death, dies, or (B) a child who received service from the Society at any time in the 12 months prior to his or her death, dies.

2. The Society will complete a Serious Occurrence Report as set out in the ministry's Serious Occurrence Reporting Procedures. The Society will immediately forward copies of the report to the Regional Office, the regional supervising coroner and the Deputy Chief Coroner (or delegate). In addition, the Society will follow the ministry's Enhanced Serious Occurrence Reporting Procedures when appropriate.

3. The Regional Office will review the Serious Occurrence Report provided and file a Contentious Issue Report (CI) according to ministry procedures. Even if a child's death may not appear to be contentious it is deemed as such for purposes of this Directive. The CI should summarize the case, ensuring no client identifying information is provided, and detail the action being taken by the Society and the Regional Office. (If information is incomplete at the time of the initial notification or preliminary inquiry, the Regional Office should indicate this, and clarify through CI up-dates as information becomes more readily available).

4. The Society will complete a case summary (using the Child Fatality Case Summary Report template). The Society may contact the Office of the Chief Coroner directly for information regarding the cause of death. The case summary will include the Society's determination as to whether the child died under questionable circumstances and/or as a result of abuse, mistreatment or parental negligence/neglect. Within 14 days of the child's death or within 14 days of learning that the child has died, the Society will forward copies of the report to the Regional Office and to the Chair of the Paediatric Death Review Committee.

5. The Chair of the Paediatric Death Review Committee will review the Child Fatality Case Summary Report, and will decide within seven days of receiving the report whether the Society must undertake an Internal Child Death Review. The Chair will notify the Society of this decision in writing and will provide a copy of this correspondence to the Regional Office.

6. If the Chair of the Paediatric Death Review Committee determines that an Internal Child Death Review is required, then the Society will conduct a full review of the case. The Society will establish a review team and will include an external reviewer with appropriate clinical expertise on the team.

7. The Society will complete a full Internal Child Death Review within 90 days of the decision made by the Chair of the Paediatric Death Review Committee. The Society will forward copies of the report to the Regional Office and to the Chair of the Paediatric Death Review Committee.

8. The Society will submit written progress reports every six months to the Regional Office when the Internal Child Death Review includes recommendations for further action or follow-up by the Society.

9. Based on the Society's Internal Child Death Review, the Office of the Chief Coroner will determine whether the Paediatric Death Review Committee will undertake a further review, and if so, how detailed a review it will be.

10. If the Paediatric Death Review Committee conducts a review, the Committee will complete the review within one year of the child's death. The Committee will forward a copy of the report to the Executive Director of the Society and to the Assistant Deputy Minister of the ministry's Program Management Division. Program Management Division will forward copies of the report to the Regional Office and to the ministry's Policy Development and Program Design Division.

11. The Society will consider the Paediatric Death Review Committee Report, will implement the recommendations as appropriate and will incorporate the recommendations addressed to the Society into its written progress reports to the Regional Office.

12. The Regional Office will maintain copies of reports, reviews, recommendations and related statistics in accordance with the ministry's Records Management Procedures.

EFFECTIVE DATE: March 31, 2006

Original Signed By:
Trinela Cane
Assistant Deputy Minister, Policy Development and Program Design Division
Ministry of Children and Youth Services

Alexander Bezzina
Assistant Deputy Minister, Program Management Division
Ministry of Children and Youth Services
Ministry of Community and Social Services

Dr. James Cairns
Deputy Chief Coroner, Ministry of Community Safety and Correctional Services

Ontario

Access/Correction Request
Freedom of Information and Protection of Privacy

Request for:

Access to General Records

Access to Own Personal Information

Correction of Own Personal Information

Name of institution request made to:

Freedom of Information and Protection of Privacy Services
Ministry of Community Safety and Correctional Services
200 First Avenue West
NORTH BAY, ON P1B 3B9
TEL: (705) 494-3850 FAX: (705) 494-3881

If request is for access to, or correction of, own personal information records:

Last name appearing on records: ☐ same as below OR TM

Details:

Last Name:	First Name:	Middle Name:	Mr. Mrs. Ms Miss

Address (Street/Apt. No./P.O. Box No./R.R. No.) City or Town Province

Postal Code	Telephone Number (s) Day TM	Area Code		Evening TM	Area Code	

Detailed description of requested records, personal information records or personal information to be corrected. (If you are requesting access to, or correction of, your personal information, please include your date of birth and identify the personal information bank or record containing the personal information, if known)

Note: If you are requesting a correction of personal information, please indicate the desired correction and, if appropriate, attach any supporting documentation. You will be notified if the correction is not made and you may require that a statement of disagreement be attached to your personal information

Preferred method of access to records	Signature	Date: Day	Month	Year
Examine Original				
Receive Copy				

EACH SEPARATE REQUEST MUST BE ACCOMPANIED BY THE $5.00 APPLICATION FEE. CHEQUE OR MONEY ORDERS SHOULD BE MADE PAYABLE TO THE MINISTER OF FINANCE.

Payment Options: ☐ CASH ☐ VISA ☐ MASTER CARD ☐ MONEY ORDER ☐ CHEQUE

Card Number: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiry Date	Amount:	Authorization Number: (For Ministry Use Only)
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Last Name:

Given Name: Initials:

Signature: Date:

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