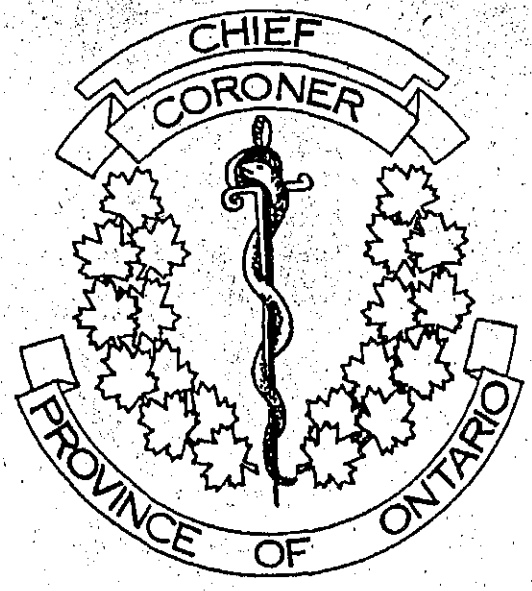


INQUEST

TOUCHING THE DEATH OF

JORDAN DESMOND HEIKAMP

JURY VERDICT AND RECOMMENDATIONS

April 2001

Ontario

Ministry of The Solicitor General / Ministère du Solliciteur général

Office of The Chief Coroner / Bureau du coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

We the undersigned / Nous soussigné

___ of / de *Toronto*

___ of / de *Toronto*

___ of / de *Toronto*

___ of / de *Toronto*

___ of / de *Toronto*

the jury serving on the inquest into the death of / dûment assermentés, formant le jury dans l'enquête sure le décès de:

Surname / Nom de famille	Given names / Prénom
Heikamp	*Jordan*

aged / âgé(e) de *5 wks.* held at / qui a été menée à *the Coroner's Inquest Courts, 15 Grosvenor Street, Toronto, Ontario*

From the / du *9th. January* to the / a la *11th. April* 20 *01*

By / Par Dr. *James T. Cairns* Coroner for Ontario / coroner pour l'Ontario

having been duly sworn, have inquired into and determined the following:/ avons enquêté at avons déterminé ce qui suit:

1.	Name of deceased / Nom du (de la) défunt(e)	*Jordan (Austin, Michael, Robert, Scott) Desmond Heikamp*
2.	Date and time of death / Date et heure du décès	*June 23rd., 1997, at 8:22am.*
3.	Place of Death / Lieu de décès	*The Hospital for Sick Children - Toronto*
4.	Cause of death / Cause du décès	*Chronic Starvation*
5	By what means / Circonstances entourant le décès	*Homicide*

The verdict was received on the / Ce verdict a été reçu par moi le *11th.* day of *April* 20 *01*

Original signed by Coroner

Distribution: Original – Regional coroner for fowarding to Chief Coroner / L'original - coroner de la région pour transmission ai coroner en chef

Copy – Crown Attorney / Copie – Procureur de la Couronne

CC 010 (Rev. 06 / 89)

Recommendations are directed to the following parties without priority.

Children's Aid Societies:

Recommendation #: 1,2,4,5,6,7,8,9,10,11,12,13,14,26,27,30,34,35,37,41

Catholic Children's Aid Society:

Recommendation #: 1,2,4,5,6,7,8,9,10,11,12,13,14,26,27,30,34,35,37,41

Ontario Association of Children's Aid Societies:

Recommendation #: 1,2,4,5,6,7,8,9,10,11,12,13,14,26,27,30,34,35,37,41

Ministry of Community and Social Services:

Recommendation #: 3,4,5,6,7,8,12,13,15,17,22,23,26,27,28,29,34,35,37,40,42,43

Ministry of Health:

Recommendation #: 8,13,16,24,28,29,30,31,32,33,34,38,39,40,42,43

Ontario Hostel Association:

Recommendation #: 4,6,7,8,15,22,26,27,41,43

Ontario Association of Interval and Transitional Housing:

Recommendation #: 4,6,7,8,15,22,26,27,41,43

Hostel Services of Toronto:

Recommendation #: 4,6,7,8,15,18,19,20,21,22,23,24,25,26,27,41,43

Canadian Union of Public Employees:

Recommendation #: 8,15

City of Toronto:

Recommendation #: 4,8,17,23,24,28,29,37,42

Shelters:

Recommendation #: 4,6,7,8,15,18,19,20,21,22,23,24,25,26,27,30,31,39,41,43

Toronto Public Health Department:

Recommendation #: 4,7,8,16,18,22,24,25,26,29,30,31,34,39,40,42,43

Hospitals and Hospital Boards:

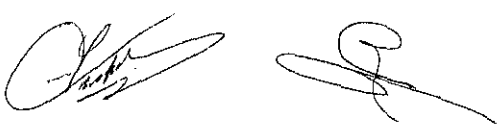
Recommendation #: 4,7,8,22,24,26,27,28,29,30,32,33,34,35,36,37,39,40

Baby Food and Formula Manufacturers:

Recommendation #: 38

Chief Coroner's Office:

Recommendation #: 44



JURY RECOMMENDATIONS CONCERNING THE DEATH OF

JORDAN DESMOND HEIKAMP

The following recommendations are not presented in any particular order of priority.

1. **We the jury recommend, that it should be made clear to all Child Protection Workers and their Child Protection Supervisors that their client is the child in need of protection not the parent or the family.**

Rationale:
The evidence shows that the focus on this case was primarily on the mother and not on the child.

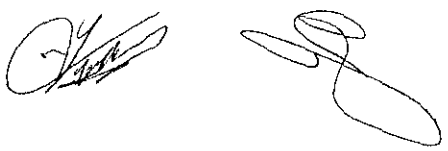
2. **We the jury recommend, that the Ontario Association of Children's Aid Societies provide assistance in an internal Children's Aid Societies review of serious incidents such as death of a child. Internal reviews by colleagues are of assistance but require the input of a neutral and critical outside reviewer. In the event of a Criminal Investigation, the Children's Aid Society should complete a full investigation unless advised in writing by the police to cease such an investigation. The general overall recommendations (not disclosing the client's or employee's names or personal information) resulting from the review should be shared with all staff as a learning tool. All child protection workers in Ontario should receive a concise overview of the facts surrounding Jordan Heikamp's death.**

Rationale:
Evidence indicated that the review was stopped before it was completed due to the police investigation.

3. **We the jury recommend, that the Ministry of Community and Social Services develop a public awareness and education program about the harmful effects of child neglect and abuse and the importance of early detection and intervention.**

4. **We the jury recommend, that the Ministry of Community and Social Services provide funding for the human resources required to undertake ongoing education to the professional community on Duty to Report.**

Rationale:
It appears that the Duty to Report obligations under the Child and Family Services Act may not be widely known. In addition, there is some confusion among various agencies and professionals as to what the duty entails and what should be reported.



5. **We the jury recommend, that the Ministry of Community and Social Services provide funding to the Children's Aid Societies for the provision of Pregnancy and After-care Services to young mothers without support, including the capacity for outreach and early intervention at the pre-natal stage.**

Rationale:
Access to pre-natal education and medical resources needs to be made available to this unique population. Children's Aid Societies can greatly assist young mothers through early intervention and outreach programs that contribute significantly to better working relationship between Children's Aid Workers and young mothers.

6. **We the jury recommend, that meetings with clients, when possible, should take place in their own surroundings (home, shelters, etc.).**

Rationale:
The worker is then able to observe how the client is coping in his/her environment, and possibly see care workers and speak to them as well as the client.

7. **We the jury recommend, that all child protection workers should be cautioned that some young people who reside or have resided in shelters have become adept at lying and manipulating. The caseworker should confirm the accuracy of information received from the caregiver whose parenting skills are being investigated and assessed, even if the caregiver presents well and there is no apparent reason to doubt him or her.**

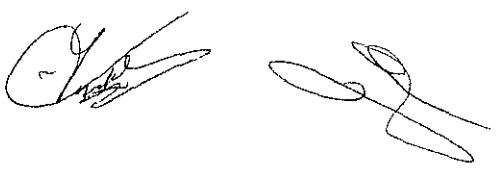
Rationale:
All observations about baby Jordan were done and discussed with his mother. Nothing was checked out or confirmed.

8. **We the jury recommend, that the Ministry of Community and Social Services and the Ministry of Health ensure that a full and comprehensive education and training program in the Street and Shelter Culture be established that addresses the needs of vulnerable children and youth and that it be for all Children's Aid Societies, Hospital, Shelter and Public Health Employees. Funding such a program provided for by both Ministries.**

Rationale:
Evidence showed there was a lack of knowledge in this area.

9. **We the jury recommend, that all Children's Aid Societies amend their policies to include a weekly face to face visit with the child where the child is a newborn infant under four (4) months of age. The twenty-one (21) days allowed for risk assessments should be shortened to seven (7) days.**

Rationale:
Evidence showed that even after the June 12th. observation, another face to face visit with baby Jordan might have confirmed in the social worker's mind that the baby had not gained weight.



10. **We the jury recommend, that all Children's Aid Societies reflect a turn around time of a minimum of fifteen (15) days as opposed to thirty (30) days for all children under six (6) years of age.**

Rationale:
Evidence showed that this age group is the most vulnerable and warrants a shorter turn around in time.

11. **We the jury recommend, that all Children's Aid Societies adopt a critical role as well as a supportive role for their social workers.**

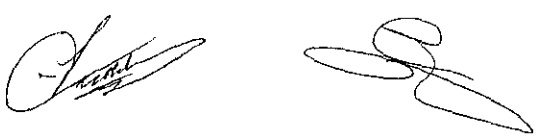
Rationale:
Evidence showed that the social worker played a supportive role or advocacy role for the mother of the child and a more critical role was required.

12. **We the jury recommend, that the Ministry of Community and Social Services accept and implement the eleven (11) recommendations set out in the "Final Report, Ontario Risk Assessment Model, Phase I: Implementation and Training" by Nico Trocme et al (1999).**

13. **We the jury recommend, that the Ministry of Community and Social Services and the Ministry of Health to provide funding to ensure that each of the Children's Aid Societies have a minimum of one Pregnancy After-Care (PAC) Worker to provide pregnancy and after-care services to first time mothers, including the capacity for outreach and early intervention at the pre-natal stage. Both Ministries should commit to the prompt implementation of the appropriate funding model so that women's and family shelters are provided with sufficient resources to adequately ensure that the pre-natal and post-natal care of children and to provide aid in the growth and development of the children at the shelters.**

14. **We the jury recommend, that Supervisors of the Children's Aid Societies should conduct regular reviews of the intake worker's files and case notes to ensure that all policies and procedures are being complied with. The supervisors should document as much as possible their involvement in a file.**

Rationale:
It was difficult to determine when the initial assessment had been completed by the intake worker and then reviewed by the supervisor.



15. **We the jury recommend, that the Ministry of Community and Social Services in conjunction with Ontario Hostel Association (OHA), Ontario Association of Interval and Transitional Housing (OAITH), the Hostel Services of Toronto, the Hostel Training Center and the Canadian Union of Public Employees (CUPE) develop and establish policies and standards for the education of shelter workers in the province that will include but not be limited to:**
    - **Dedicated funding for educational training and back fill costs**
    - **Designated and dedicated number of days per year for each employee to devote to training**
    - **Pre-workload training period for new employees**
    - **Components dealing with documentation**
    - **Components dealing with interview skills and verification of information**
    - **Components dealing with Models of Care and Plans of Action**
    - **Components dealing with Failure to Thrive**
    - **Components dealing with the Child and Family Services Act**

Rationale:
To recognize the on-going needs for shelter workers to receive training in order to carry out their duties and responsibilities in a manner that will meet the needs of the client.

16. **We the jury recommend, that the Ministry of Health increase funding to the Public Health Departments and the "Healthy Babies, Healthy Children" Programs to provide mandatory home visits to mothers who receive a "high risk" score on the "Healthy Babies, Healthy Children" screening tools and to provide outreach on a regular basis to Youth Shelters and Women's Shelters to ensure the provision of:**
    - **Health education**
    - **Routine health assessments, and feeding and care of baby**
    - **Effective linkages and referral with other medical professionals.**

17. **We the jury recommend, that the Ministry of Community and Social Services and the City of Toronto should look into the feasibility of opening another shelter like Robertson House with similar services and programs. We suggest this shelter be called "Jordan's House".**

Rationale:
It has been proven that there is a lack of appropriate facilities available for pregnant street and shelter youth.

18. **We the jury recommend, that the City of Toronto Hostel Services develop a protocol to be incorporated into Hostel Standards for shelters that require immediate notification to the Public Health Department of the admission of a young pregnant woman without support to a shelter.**

19. **We the jury recommend, that the City of Toronto Hostel Services work with each youth and family shelter to ensure that they include consent forms to be signed by the client, in particular, youth at intake. This enables the sharing of information between shelters and the tracking of young pregnant women in the shelter system.**

20. **We the jury recommend, that if arrangements have been made for a pregnant teenager to check into a maternity home on a specific date, a care worker should accompany her.**

Rationale:
Evidence indicated that a young pregnant woman was put into a taxi, but never showed up at the maternity home.

21. **We the jury recommend, that Shelter staff should not wait for clients to ask for help, because you cannot make them ask (they may not see the need). Help should be offered and it should be up to the staff to evaluate whether help is needed. Assess the situation on a regular basis.**

22. **We the jury recommend, that information on birth control, pregnancy, counseling and other health related topics should be easy to access at youth serving agencies and appropriate for this population. Use of other sites where street youth may gather should be used (in malls, bus stations, etc.) for outreach and information dissemination.**

23. **We the jury recommend, that many graduates from the Assaulted Women's and Children's Counselor/Advocate Program become front line workers in homeless shelters within the Toronto area. Many of their students' field placements are in these shelters. It is critical that this program provides more training and education in the area of child development and parenting techniques.**

24. **We the jury recommend, that the Public Health's services for at-risk mothers be widely advertised to doctors, shelter workers and street workers who have a support relationship with street youth. The Public Health intake telephone number (416-338-7600) should be on display in locations that are frequented by homeless youth.**

25. **We the jury recommend, that ongoing education and counseling including parenting, life-skills and nutrition should be available in family shelters and at drop-ins, delivered by public health nurses and others associated with these facilities.**

26. **We the jury recommend, that the Child and Family Services Act should be amended to include a new provision in Part III (Child Protection) that authorizes child protection agencies to have access to information and records related to a person, without the need for that person's consent or a court order, in the following circumstances:**
    - **If the information is believed to be necessary to investigate allegations that a child is or may be in need of protection;**
    - **For the purpose of a proceeding or possible proceeding under Part III (Child Protection) of the Child and family Services Act;**
    - **If the information is necessary for monitoring court orders.**

Rationale:
A free flow of information is critical to the care of infants like baby Jordan.

27. **We the jury recommend, that all persons working in shelters where newborns sometimes stay should receive a concise overview of the facts surrounding the death of Jordan Heikamp. This statement should emphasize the importance of:**
    - **Exercising caution in relying on the word of a child's caregiver.**
    - **Ensuring that, when a child protection worker is involved, the shelter workers and the child protection worker have a clear, detailed understanding of exactly what each will be doing and not doing in relation to a vulnerable child who is living in a shelter. A written statement of this mutual understanding should normally be prepared.**

    The Ministry of Community and Social Services license shelters that provide staffed residential services to women and children. The licensing requirements will address standards of service, appropriate staffing levels and other issues, which contribute to the safety of the residents, including:
    - **Pregnant youth residing in shelters will be expected to participate in appropriate pre-natal programs and care;**
    - **Youth shelters and shelters for women and children will be expected to develop a service arrangement with a consistent medical practitioner on their local community;**
    - **Shelters providing care to children and their parents must consider the child as an individual client, including a plan for services required to meet the child's needs;**
    - **Regular observation and assessment should be made regarding both adult and child residents of shelters;**
    - **All shelters that provide residential services to mothers with infants require verification of routine medical visits for the infant up to twelve (12) months of age.**

Rationale:
In order to effectively service this population it is imperative that a policy be developed that will clarify what services a shelter does and does not offer.

28. **We the jury recommend, that in addition to adequate nursing staff on hospital obstetrical units and nurseries, hospitals should be encouraged to have a designated lactation consultant on staff.**

29. **We the jury recommend, that funding should be provided to clinics, hospitals and public health departments for the hiring of lactation consultants, nurses and/or midwives. Funding should be sufficiently allocated to ensure that twenty-four (24) hour breastfeeding clinics are available.**

Rationale:
Designated lactation consultants make it easier for hospitals to ensure that all mothers learn how to breastfeed especially in situations where the mother has a short stay at the hospital or she is discharged before the baby.

30. **We the jury recommend, that mothers whose "Healthy Baby, Healthy Children" screening tool score exceeds, for example twenty-five (25), should receive a home visit from a Public Health Nurse. This should occur even if a Children's Aid Society has been notified about the child's situation.**

31. **We the jury recommend, that the Public Health Nurse must visit at least once a week. Equipment must be available, such as a weigh scale, etc. The Public Health Nurse should check infants less than four (4) months old (physical check-ups, weighing, etc.).**

Rationale:
Relying on others proved to be critical in baby Jordan's life.

32. **We the jury recommend, that a standardized and mandatory discharge sheet or "passport" be developed by the Ministry of Health and used by all hospitals. This form will be available to all hospitals within a defined period of time. It should include at the very least:**
    - **Date of Birth, weight at birth**
    - **Complications, abnormalities or illnesses treated**
    - **Immunizations given**
    - **Screenings done (for example: Thyroid and PKU)**
    - **Feeding at the time of discharge; type of milk, amounts per feed, frequency**
    - **Weight at discharge**
    - **Date and time of follow-up, within seven (7) days, and name of follow-up health professional**
    - **Special tests (for example: Hearing tests) or special appointments.**

    A written summary should be provided to all mothers at the time of hospital discharge. This may take the form of an "infant passport" or a pre-structured summary in the form of Exhibit #102

Rationale:
In 1997, some hospitals did not have such a form for hospital staff to give to new mothers. It is agreed that the form developed by Hamilton-Wentworth in 1999 would be a useful tool to model a uniform discharge summary (Exhibit #102). Some amendments should be made to the form (for example: The method of feeding should be included).

33. **We the jury recommend, that if the mother is discharged before the baby, a duplicate of all information in the mother's file should be transferred to the baby's file.**

34. **We the jury recommend, that when a newborn is discharged from hospital and a child protection worker has undertaken to investigate and assess the parenting capacity of the child's primary caregiver, the child protection worker should confirm with hospital staff that an appointment has been made for the child to be seen by a health care provider, and the child protection worker should subsequently confirm with the health care provider that the appointment was kept.**

Rationale:
In this case, there was no follow-up care by a physician. The hospital and the Catholic Children's Aid Society had a different understanding as to who the follow-up physician was. No verification was made to ensure that the mother actually took baby Jordan to the doctor. Mandatory verification is not necessary for all mothers, but only mothers who are identified as high risk.

35. **We the jury recommend, that hospitals and child protection agencies should review policies to ensure clear communication between hospital staff and child protection workers. Input from the hospital staff regarding concerns should be fully communicated and assessed by the child protection agency. Face to face meetings by the assigned child protection worker and all relevant hospital staff should be encouraged and arranged by the child protection worker when hospital staff raises concerns. Information flow should be both ways. In addition to obtaining all relevant information from hospital staff, child protection agencies should inform staff of the relevant issues (for example: transportation issues and eating disorders) which may be important for the baby's care while in the hospital.**

Rationale:
There is evidence that the social worker did not hold meetings with the nurses and did not review hospital records.

36. **We the jury recommend, that it be suggested that each Hospital Board delegate an individual who will be responsible to look at the recommendations submitted by this jury and the feasibility of their implementation. This person could also be responsible for on-going education, monitoring of pre and post-natal discharge policies, and maintaining contact with relevant community groups in their geographic area.**

37. **We the jury recommend, that when hospital staff make a referral to a Children's Aid Society regarding a child, the hospital will automatically involve the Hospital Social Worker. The social worker will remain involved with the nursing staff to resolve problems as they arise in the hospital, along with:**
    - **Act as liaison between hospital, family and the Children's Aid Society, to share and provide information as required and/or permitted by law;**
    - **Assist in any required follow-up intervention when appropriate;**
    - **Will remain involved with the family care while the baby and/or mother remain in the hospital, even when a referral has been made to a Child Welfare Agency**

    In situations where there is no Hospital Social Worker one person should be assigned to discharge the facilitative role.

Rationale:
Where a child, particularly a newborn infant, is transferred from the medical system to the child welfare system, there is need to ensure that the move occurs with optimal communication.

38. **We the jury recommend, that manufacturers of all baby formula should put on the labels of their product a warning of the danger of diluting the formula without the specific recommendation of a physician. This warning to be placed in a conspicuous place on the label.**

Rationale:
The mother of baby Jordan was diluting the formula to such a degree that any nourishment supplied was insufficient for him to survive on.

39. **We the jury recommend, that any mother discharged from hospital intending to breastfeed, but where the feeding has not been established, are seen within 24-48 hours by a lactation consultant. Also that signs of infant hydration and successful breastfeeding be taught in the pre and post-natal periods, along with the proper hygiene care of breasts. The appointment for the lactation consultant be included in the standardized discharge summary, and where appropriate, the same verification system as for doctors visits be in place:**
    - **Information regarding breast or bottle feeding difficulties, and how to recognize when feeding is going well and signs of distress;**
    - **Twenty-four (24) hour availability of hospital nursery nurses;**
    - **Twenty-four (24) hour telephone number for breastfeeding information and assistance.**

Rationale:
Proper care of a newborn infant can only be provided if those responsible for that care are aware of the infant's needs and are capable of meeting those needs.

40. **We the jury recommend, that the "Healthy Babies, Healthy Children" Postpartum screening tool should be completed and forwarded to Public Health for all children regardless of consent. Sufficient funding should be allocated to the "Healthy Babies, Healthy Children" program to allow the implementation of the entire program's phases.**

Rationale:
Evidence was given that the volume is often too great to make all of the calls within forty-eight (48) hours of discharge and Public Health does not have sufficient nurses to staff the program due to nursing shortages in the province. Increased funding for staffing is necessary to ensure continuance and full implementation of this vital program. The program should be mandatory and home visits should be implemented in all cases where significant risk factors are identified.

41. **We the jury recommend, that all shelter workers should be precise in describing to outside agencies the services that their shelter can provide. In particular, if a shelter employs persons who have nursing experience but did not employ those persons to deliver nursing services, then the shelter's workers must be sure not to say anything which might create the mistaken impression that the shelter offers nursing services.**

Rationale:
Two (2) shelter workers, with nursing experience, were hired as counsellors but the mistaken impression was given that nursing services were offered. This created a false security with the social worker and mother of baby Jordan.

42. **We the jury recommend, that programs like "Healthy Connections – Community Programs" which reach out to various communities within Toronto by medical practitioners, continue to be recognized and supported by all levels of government.**

Rationale:
Evidence revealed a practical medical outreach program which is already in place and which has worked well.

43. **We the jury recommend, that the Public Health Departments and "Healthy Babies, Healthy Children" programs should provide outreach on a regular basis to Youth Shelters and Women's and Family Shelters, which provide residential services to women and children to ensure provision of:**
    - **Health education**
    - **Routine health assessment**
    - **Effective linkages and referral with other medical professions.**

Rationale:
The special needs and circumstances of this population must be addressed in order to ensure that appropriate health care is available.

44. **We the jury recommend, that the Chief Coroner's Office within one (1) year of the anniversary date of this inquest provide a report on the implementation of the above recommendations.**

LETTER OF EXPLANATION OF THE JURY'S VERDICT

FOR THE INQUEST INTO THE DEATH OF JORDAN DESMOND HEIKAMP

Deceased: June 23, 1997

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 interpretation of the evidence and the Jury's rationale for recommendations. My sole purpose for this is to assist the reader to more fully Understand the Verdict and recommendations of the Jury and is not intended to be considered as the actual evidence presented at the Inquest. It is in no way intended to replace the Jury's Verdict.

HISTORY

This Inquest started the 8th of January, 2001 and finished on the 11th of April, 2001 During that period there were sixty-four (64) sitting days and the Jury heard from 56 witnesses. The investigating officers for the Inquest were Det. Dave Needham and Det. Frank Simone of the Toronto Police. The Coroner's constable was Ernie Drummond and the court reporter was Liz Retzer ((416) 266-3323). The Coroner's counsel was Mr. John Sutherland assisted by Mr. Bob Ash.

The following parties had standing at the Inquest:

1. Renee Heikamp represented by Ms. Rochman
2. Angie Martin represented by Mr. Hainey and Ms. Cole
3. The Catholic Children's Aid Society of Toronto represented by Mr. Paul French
4. The Anduhyaun Sshelter represented by Ms. Hare
5. Northwestern Hospital nurses represented by Ms. Hughes
6. Northwestern Hospital represented by Mr. P. Hawkins
7. Dr. Gans represented by Mr. Neuman
8. The Canadian Union of Public Employees represented by Ms. Pancer
9. Horizons Shelter represented by Mr. Dizgun

Jordan Heikamp was born on the 19th of May 1997 by c-section at the Northwestern Hospital. His mother was Renee Heikamp who was nineteen years old at the time of the birth. The baby was slightly premature at birth and weighed 4 lbs. 6 oz.

Renee Heikamp a troubled youth had left home at the age of sixteen. She spent some time with the circus and over the last few years had been living in the shelter system in Toronto. She had moved from shelter to shelter during her time in Toronto and had developed what her lawyer called a "shelter culture". Evidence was given that homeless youth and those living in shelters in Toronto learn how to manipulate the system in order to survive. The

manipulation takes many forms including outright lying about events if they feel it will help their needs.

During her pregnancy Renee was staying initially at Youth without Shelter which does not accept newborn babies and the counsellors therefore arranged for Rene to be accepted into Massey House which is a pregnancy home for single mothers. Renee was actually placed in a taxi by a Youth Without Shelter counsellor with the expectation that she was going to Massey House. Instead Renee went to another shelter Horizons where she stayed for the reminder of her pregnancy. The evidence indicated that throughout the pregnancy apart from a few Emergency Department visits Renee had no regular anti-natal care.

After Jordan was delivered by c-section at Northwestern hospital on the 19th of May, 1997 Renee discharged herself on the 21st of May, 1997. The nurses looking after Jordan were concerned about her ability to care for Jordan and her apparent lack of interest in visiting Jordan, who remained in hospital because of his prematurity.

The nurses notified the Catholic Children's Aid Society of Toronto of their concerns and Ms. Angie Martin was the intake social worker assigned to the case.

After assessment it was decided that Jordan would only be able to leave hospital with Renee if suitable accommodation for her was found. In due course, Anduhyaun Shelter which is a native shelter for abused women agreed to take Renee and her baby. On the 29th of May the baby was discharged with Angie Martin and Renee to the Anduhyaun Shelter. At that time Jordan weighed 4 lbs. 15 oz.

Jordan stayed at the Anduhyaun Shelter until his death on the 26th of June, 1997. There was a massive amount of evidence presented with regard the role Anduhyaun was to play in monitoring Jordan and the role that the Catholic Children's Aid Society was to play. Much of this evidence was contradictory and many of the Jury's recommendations relate to that issue.

In summary, it is sufficient at this time to say that while at the shelter Jordan was being fed by his mother Renee, by both breast and bottle. Renee spent a lot of her time away from the shelter visiting her friends at Horizons.

During Jordan's stay at Anduhyaun, Renee had one meeting with the social worker, Angie Martin, in her office on June 12th. Jordan was with her at that time. On that visit Renee indicated that she had taken Jordan to Dr. Gans (Paediatrician) who said that he was gaining weight, weighed 5 lbs. 1 oz. and was doing well.

Renee admitted on the witness stand that in fact she never took Jordan to see Dr. Gans or any other doctor.

On the 23rd of June, 1997 Jordan was found dead in bed by Renee Heikamp. At autopsy he weighed 4 lbs. 2 oz. and was found to have died from chronic starvation. Dr. John Watts an expert for the Coroner's Office indicated that the weight loss was due to lack of food and

the infant had been receiving 25% or less of his normal daily requirements for a period of up to 2 to 3 weeks before death. At the time of his death Jordan was 35 days old.

In their Verdict the Jury concluded that Jordan had died of chronic starvation. They also indicated that the "By What Means" was "Homicide".

In his closing address to the Jury the Coroner's Counsel, Mr. Sutherland, indicated to the Jury that if they found there was clear and cogent evidence of the following points then they could consider Homicide as a possible verdict:

1. Renee Heikamp was the person responsible for feeding Jordan after his discharge from the hospital.
2. She had fed him diluted formula without reading the instructions on the can.
3. She had admitted to lying about taking the baby to Dr. Gans and admitted lying about the baby's weight.
4. Medical evidence indicated that the child had no disease and had died purely of chronic starvation.
5. The expert indicated that Jordan would have looked as emaciated as his autopsy photograph showed for at least a number of days if not a week before his death.

Having listened to all the evidence on the issue of "By What Means" the Jury accepted the above points and came back with "Homicide".

They made forty-four (44) recommendations aimed at the prevention of a similar tragedy in the future.

At the start of the recommendations they catalogued the various agencies the Verdict should be sent to and this should be of great help in distributing.

RECOMMENDATION #1

We the jury recommend, that it should be made clear to all Child Protection Workers and their Child Protection Supervisors that their client is the child in need of protection not the parent or the family.

Rationale for Recommendation #1

The evidence shows that the focus on this case was primarily on the mother and not on the child.

Explanation:

I agree with the Jury's rationale that the focus on this case was primarily on the mother and not on the child. The evidence indicated lots of notations were made regarding Renee by both Anduhyaun and the Children's Aid Society and it

appeared at many times as if Jordan was almost invisible. In the Anduhyaun records it states "Renee Heikamp plus 1". This first recommendation really stresses the importance of who is the client and re-enforces recent amendments to the Child and Family Services Act, that the child's needs is the paramount issue that needs to be looked after by a Children's Aid Society.

RECOMMENDATION #2

We the jury recommend, that the Ontario Association of Children's Aid Societies provide assistance in an internal Children's Aid Societies review of serious incidents such as death of a child. Internal reviews by colleagues are of assistance but require the input of a neutral and critical outside reviewer. In the event of a Criminal Investigation, the Children's Aid Society should complete a full investigation unless advised in writing by the police to cease such an investigation. The general overall recommendations (not disclosing the client's or employee's names or personal information) resulting from the review should be shared with all staff as a learning tool. All child protection workers in Ontario should receive a concise overview of the facts surrounding Jordan Heikamp's death.

Rationale for Recommendation #2

Evidence indicated that the review was stopped before it was completed due to the police investigation.

Explanation:

In this case the Children's Aid Society did not complete the review required by the Ministry of Community and Social Services because criminal charges were laid subsequent to the death. In this recommendation the Jury are also advising that all child protection workers in Ontario should receive a concise overview of the facts surrounding Jordan Heikamp's death. I will ensure that this is done and will be asking for the assistance of the Catholic Children's Aid Society and the Ontario Association Children's Aid Societies to carry out this part of the recommendation.

RECOMMENDATION #3

We the jury recommend, that the Ministry of Community and Social Services develop a public awareness and education program about the harmful effects of child neglect and abuse and the importance of early detection and intervention.

Rationale for Recommendation #3 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #4

We the jury recommend, that the Ministry of Community and Social Services provide funding for the human resources required to undertake ongoing education to the professional community on Duty to Report.

Rationale for Recommendation #4

It appears that the Duty to Report obligations under the Child and Family Services Act may not be widely known. In addition, there is some confusion among various agencies and professionals as to what the duty entails and what should be reported.

Explanation -- Self-explanatory.

RECOMMENDATION #5

We the jury recommend, that the Ministry of Community and Social Services provide funding to the Children's Aid Societies for the provision of Pregnancy and After-care Services to young mothers without support, including the capacity for outreach and early intervention at the pre-natal stage.

Rationale for Recommendation #5

Access to pre-natal education and medical resources needs to be made available to this unique population. Children's Aid Societies can greatly assist young mothers through early intervention and outreach programs that contribute significantly to better working relationship between Children's Aid Workers and young mothers.

Explanation -- Self-explanatory.

RECOMMENDATION #6

We the jury recommend, that meetings with clients, when possible, should take place in their own surroundings (home, shelters, etc.).

Rationale for Recommendation #6

The worker is then able to observe how the client is coping in his/her environment, and possibly see care workers and speak to them as well as the client.

Explanation:

While Jordan was at the Anduhyaun Shelter the C.A.S. worker never visited the shelter and hence missed an opportunity to observe how Jordan was doing in his environment and also have an ability to speak to other people at the shelter regarding Jordan.

RECOMMENDATION #7

We the jury recommend, that all child protection workers should be cautioned that some young people who reside or have resided in shelters have become adept at lying and manipulating. The caseworker should confirm the accuracy of information received from the caregiver whose parenting skills are being investigated and assessed, even if the caregiver presents well and there is no apparent reason to doubt him or her.

Rationale for Recommendation #7

All observations about baby Jordan were done and discussed with his mother. Nothing was checked out or confirmed.

Explanation:

It is clear that in this case everything Renee told the social worker was accepted at face value without any checking. It was obvious from the evidence that young people who reside in shelters have become adapt at lying and manipulating and therefore it is extremely important to confirm the accuracy of information received from the caregiver and not to just accept it at face value. If the information supplied by Renee regarding her visit to Dr. Gans had been independently checked the outcome may well have been different.

RECOMMENDATION #8

We the jury recommend, that the Ministry of Community and Social Services and the Ministry of Health ensure that a full and comprehensive education and training program in the Street and Shelter Culture be established that addresses the needs of vulnerable children and youth and that it be for all Children's Aid Societies, Hospital, Shelter and Public Health Employees. Funding such a program provided for by both Ministries.

Rationale for Recommendation #8

Evidence showed there was a lack of knowledge in this area.

Explanation:

The whole sub-culture of street youth and shelters is obviously not understood by many people in the medical profession, the Children's Aid Societies, public health employees, etc. and education of the sub-culture would be extremely valuable.

RECOMMENDATION #9

We the jury recommend, that all Children's Aid Societies amend their policies to include a weekly face to face visit with the child where the child is a newborn infant under four (4) months of age. The twenty-one (21) days allowed for risk assessments should be shortened to seven (7) days.

Rationale for Recommendation #9

Evidence showed that even after the June 12th observation, another face-to-face visit with baby Jordan might have confirmed in the social worker's mind that the baby had not gained weight.

Explanation -- Self-explanatory.

RECOMMENDATION #10

We the jury recommend, that all Children's Aid Societies reflect a turn around time of a minimum of fifteen (15) days as opposed to thirty (30) days for all children under six (6) years of age.

Rationale for Recommendation #10

Evidence showed that this age group is the most vulnerable and warrants a shorter turn around in time.

Explanation:

Since newborn babies health can change dramatically over a short period of time it is necessary to have an action plan in place much sooner for this type of client and the Jury are recommending that this should be done within fifteen (15) days to at least meet the immediate needs of the infant. Obviously, further planning may need to be done at a later stage but this first month of the child's life is critical.

RECOMMENDATION #11

We the jury recommend, that all Children's Aid Societies adopt a critical role as well as a supportive role for their social workers.

Rationale for Recommendation #11

Evidence showed that the social worker played a supportive role or advocacy role for the mother of the child and a more critical role was required.

Explanation:

Here the Jury are dealing with a long-standing problem that C.A.S. workers have in terms of the balance between being supportive of the mother and at the same time being an advocate for the child. The Jury are stressing that this supportive role for the mother needs to be done keeping in mind that the child is the client and its needs must always come first.

RECOMMENDATION #12

We the jury recommend, that the Ministry of Community and social Services accept and implement the eleven (11) recommendations set out tin the "Final Report, Ontario Risk Assessment Model, Phase I: Implementation and Training" by Nico Trocme et al (1999).

Rationale for Recommendation #12 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #13

We the jury recommend, that the Ministry of Community and Social Services and the Ministry of Health to provide funding to ensure that each of the Children's Aid Societies have a minimum of one Pregnancy After-Care (PAC) Worker to provide pregnancy and after-care services to first time mothers, including the capacity for outreach and early intervention at the pre-natal stage. Both Ministries should commit to the prompt implementation of the appropriate funding model so that women's and family shelters are provided with sufficient resources to adequately ensure that the pre-natal and post-natal care of children and to provide aid in the growth and development of the children at the shelters.

Rationale for Recommendation #13 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #14

We the jury recommend, that Supervisors of the Children's Aid Societies should conduct regular reviews of the intake worker's files and case notes to ensure that all policies and procedures are being complied with. The supervisors should document as much as possible their involvement in a file.

Rationale for Recommendation #14

It was difficult to determine when the initial assessment had been completed by the intake worker and then reviewed by the supervisor.

Explanation:

In this case it was difficult from the documentation to determine when the initial assessment had been completed by the social worker and then subsequently reviewed by the supervisor. The Jury feel that clearer documentation may have assisted in preventing this confusion.

RECOMMENDATION #15

We the jury recommend, that the Ministry of Community and Social Services in conjunction with Ontario Hostel Association (OHA), Ontario Association of Interval and Transitional Housing (OAITH), the Hostel Services of Toronto, the Hostel Training center and the Canadian Union of Public Employees (CUPE) develop and establish policies and standards for the education of shelter workers in the province that will include but not be limited to:

- *Dedicated funding for education training and back fill costs*
- *Designated and dedicated number of days per year for each employee to devote to training*
- *Pre-workload training period for new employees*
- *Components dealing with documentation*
- *Components dealing with interview skills and verification of information*
- *Components dealing with Models of Care and Plans of Action*
- *Components dealing with Failure to Thrive*
- *Components dealing with the Child and Family Services Act*

Rationale for Recommendation #15

To recognize the on-going needs for shelter workers to receive training in order to carry out their duties and responsibilities in a manner that will meet the needs of the client.

Explanatory -- Self-explanatory.

RECOMMENDATION #16

We the jury recommend, that the Ministry of Health increase funding to the Public Health Departments and the "Health Babies, Healthy Children" Programs to provide mandatory home visits to mothers who receive a "high risk" score on the "Healthy Babies, Healthy Children" screening tools and to provide outreach on a regular basis to Youth Shelters and Women's Shelters to ensure the provision of:

- *Health education*
- *Routine health assessments, and feeding and care f baby*
- *Effective linkages and referral with other medical professionals*

Rationale for Recommendation #16 – None given.

Explanatory:

The Jury were extremely impressed by the "Healthy Babies, Healthy Children Program" that is now in placed. This program was not in placed in 1997 but is so valuable that the Jury feel this recommendation should be implemented.

RECOMMENDATION #17

We the jury recommend, that the Ministry of Community and social Services and the City of Toronto should look into the feasibility of opening another shelter like Robertson House with similar services and programs. We suggest this shelter be called "Jordan's House".

Rationale for Recommendation #17

It has been proven that there is a lack of appropriate facilities available for pregnant street and shelter youth.

Explanation -- Self-explanatory.

RECOMMENDATION #18

We the jury recommend, that the City of Toronto Hostel Services develop a protocol to be incorporated into Hostel Standards for shelters that require immediate notification to the Public Health department of the admission of a young pregnant woman without support to a shelter.

Rationale for Recommendation #18 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #19

We the jury recommend, that the City of Toronto Hostel Services work with each youth and family shelter to ensure tat they include consent forms to be signed by the client, in particular, youth at intake. This enables the sharing of information between shelters and the tracking of young pregnant women in the shelter system.

Rationale for Recommendation #19 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #20

We the jury recommend, that if arrangements have been made for a pregnant teenager to check into a maternity home on a specific date, a care worker should accompany her.

Rationale for Recommendation #20

Evidence indicated that a young pregnant woman was put into a taxi, but never showed up at the maternity home.

Explanation:

Although Renee was put in a taxi with every anticipation that she was going to go to the Massey Pregnancy Centre she did not turn up. With the information gained at this Inquest into the shelter culture of lying and manipulation the Jury feel that it would be appropriate for a worker to actually go with a client in his type of situation.

RECOMMENDATION #21

We the jury recommend, that Shelter staff should not wait for clients to ask for help, because you cannot make them ask (they may not see the need). Help should be offered and it should be up to the staff to evaluate whether help is needed. Assess the situation on a regular basis.

Rationale for Recommendation #21 – None given.

Explanation:

It was the evidence of the Anduhyaun Shelter staff that they were supplying a bed and food to Renee and her baby but were not otherwise actively monitoring whether help was needed or not. There was great confusion between what the Anduhyaun worker's role was and what the C.A.S. worker felt they should be doing.

RECOMMENDATION #22

We the jury recommend, that information on birth control, pregnancy, counseling and other health related topics should be easy to access at youth serving agencies and appropriate for this population. Use of other sites where street youth may gather should be used (in malls, bus stations, etc.) for outreach and information dissemination.

Rationale for Recommendation #22 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #23

We the jury recommend, that many graduates from the Assaulted Women's and Children's Counselor/Advocate Program become front line workers in homeless shelters within the Toronto area. Many of their students' field placements are in these shelters. It is critical that this program provides more training and education in the are of child development and parenting techniques.

Rationale for Recommendation #23 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #24

We the jury recommend, that the Public Health's services for at-risk mothers be widely advertised to doctors, shelter workers and street workers who have a support relationship with street youth. The Public Health intake telephone number (41y6-338-7600) should be on display in locations that are frequented by homeless youth.

Rationale for Recommendation #24 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #25

We the jury recommend, that ongoing education and counseling including parenting, life-skills and nutrition should be available in family shelters and at drop-ins, delivered by public health nurses and others associated with these facilities.

Rationale for Recommendation #25 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #26

We the jury recommend, that the Child and Family Services Act should be amended to include a new provision in Part III (Child Protection) that authorizes child protection agencies to have access to information and records related to a person, without the need for that person's consent or a court order, in the following circumstances:

- *If the information is believed to be necessary to investigate allegations that a child is or may be in need of protection;*
- *For the purpose of a proceeding or possible proceeding under Part III (Child Protection) of the Child and Family Services Act;*
- *If the information is necessary for monitoring court orders.*

Rationale for Recommendation #26

A free flow of information is critical to the care of infants like baby Jordan.

Explanation -- Self-explanatory.

RECOMMENDATION #27

We the jury recommend, that all persons working in shelters where newborns sometimes stay should receive a concise overview of the facts surrounding the death of Jordan Heikamp. This statement should emphasize the importance of:

- *Exercising caution in relying on the word of a child's caregiver.*
- *Ensuring that, when a child protection worker is involved, the shelter workers and the child protection worker have a clear, detailed understanding of exactly what each will be doing and not doing in relation to a vulnerable child who is living in a shelter. A written statement of this mutual understanding should normally be prepared.*

The Ministry of Community and Social Services license shelters that provide staffed residential services to women and children. The licensing requirements will address standards of service, appropriate staffing levels and other issues, which contribute to the safety of the residents, including:

- *Pregnant youth residing in shelters will be expected to participate in appropriate pre-natal programs and care;*
- *Youth shelters and shelters for women and children will be expected to develop a service arrangement with a consistent medical practitioner on their local community;*
- *Shelters providing care to children and their parents must consider the child as an individual client, including a plan for services required to meet the child's needs;*
- *Regular observation and assessment should be made regarding both adult and child residents of shelters;*

- *All shelters that provide residential services to mothers with infants require verification of routine medical visits for the infant up to twelve (12) months of age.*

Rationale for Recommendation #27

In order to effectively service this population it is imperative that a policy be developed that will clarify what services a shelter does and does not offer.

Explanation:

The evidence seemed to indicate that the Catholic Children's Aid Society and the Anduhyaun Shelter did not have a clear understanding of each others role. This led to many wrong assumptions being made and should certainly be prevented in the future. On many occasions a Children's Aid Society will be using outside agencies to assist them in the care of the child they are monitoring. It was stated quite clearly at the Inquest that although a Children's Aid Society may be requiring the assistance of outside agencies the prime responsibility for the care of the child still remains with the Children's Aid Society. The Jury feel and I must say I agree whole heartily that it is extremely important the precise role being carried out by an outside agency be understood by the agency and by the Children Aid's Society and that it would be preferable that a written statement of this mutual understanding be prepared.

RECOMMENDATION #28

We the jury recommend, that in addition to adequate nursing staff on hospital obstetrical units and nurseries, hospitals should be encouraged to have a designated lactation consultant on staff.

Rationale for Recommendation #28 -- None given.

Explanation:

There was much evidence given at the Inquest with regard to the ability of Renee to breastfeed her child. Evidence was given that even though experienced obstetrical nurses are very good at educating young mothers on breastfeeding there are occasions when the special services of a lactation consultant are needed. Having said that there is no clear evidence in this case that Renee clearly indicated to the hospital staff or the shelter staff that she was having difficulty breastfeeding and would like to see a lactation consultant.

RECOMMENDATION #29

We the jury recommend, that funding should be provided to clinics, hospitals and public health departments for the hiring of lactation consultants, nurses and/or midwives. Funding should be sufficiently allocated to ensure that twenty-four (24) hour breastfeeding clinics are available.

Rationale for Recommendation #29

Designated lactation consultants make it easier for hospitals to ensure that all mothers learn how to breastfeed especially in situations where the mother has a short stay at the hospital or she id discharged before the baby.

Explanation -- As per # 28.

RECOMMENDATION #30

We the jury recommend, that mothers whose "Healthy Baby, Healthy Children" screening tool score exceeds, for example twenty-five (25), should receive a home visit from a Public Health Nurse. This should occur even if a Children's Aid Society has been notified about the child's situation.

Rationale for Recommendation #30 – None given.

Explanation:

Evidence at this Inquest indicate that when a healthy baby screen is used and results in a case being referred to a Children's Aid Society that a public health nurse does not carry out a home visit. It is considered the responsibility of a Children's Aid Society to follow-up. The Jury felt that the "Healthy Babies, Healthy Children" program nurses are so well trained that some arrangements should be made even though Children's Aid Society are looking after the child for the public health still do a mandatory visit. I am aware that many Children's Aid Societies have now adopted a policy where their nurses will carry out this role and therefore in those cases this may be duplication of services.

RECOMMENDAITON #31

We the jury recommend, that the Public Health Nurse must visit at least once a week. Equipment must be available, such as a weigh scale, etc. The Public Health Nurse should check infants less than four (4) months old (physical check-ups, weighing, etc.).

Rationale for Recommendation #31

Relying on others proved to be critical in baby Jordan's life.

Explanation -- Self-explanatory.

RECOMMENDATION #32

We the jury recommend, that a standardized and mandatory discharge sheet or "passport" be developed by the Ministry of Health and used by all hospitals. This form will be available to all hospitals within a defined period of time. It should include at the very least:

- *Date of birth, weight at birth*
- *Complications, abnormalities or illnesses treated*
- *Immunizations given*
- *Screenings done (for example: Thyroid and PKU)*
- *Feeding at the time of discharge; type of milk, amounts per feed, frequency*
- *Weight at discharge*
- *Date and time of follow-up, within seven (7) days, and name of follow-up health professional*
- *Special tests (for example: hearing tests) or special appointments.*

A written summary should be provided to al mothers at the time of hospital discharge. This may take the form of an "infant passport" or a pre-structured summary in the form of Exhibit #102.

Rationale for Recommendation #32

In 1997, some hospitals did not have such a form for hospital staff to give to new mothers. It is agreed that the form developed by Hamilton-Wentworth in 1999 would be useful tool to model a uniform discharge summary (Exhibit #102). Some amendments should be made to the form (for example: The method of feeding should be included).

Explanation:

At the time of Jordan's discharge there was no official discharge sheet or passport given to the mother or the Children's Aid worker. At that time the Northwestern Hospital as well as many other hospitals did not have such a discharge summary. Evidence at the Inquest indicated that many hospitals do have this type of form and that it would be valuable for this form to be given to all new mothers when they leave hospital.

RECOMMENDATION #33

We the jury recommend, that if the mother is discharged before the baby, a duplicate of all information in the mother's file should be transferred to the baby's file.

Rationale for Recommendation #33 – None given.

Explanation:

In this case Renee Heikamp left the hospital after two days but her baby stayed on because it was premature. There was much useful information in the mother's file that may have been of assistance had it had been transferred to the baby's file.

RECOMMENDATION #34

We the jury recommend that when a newborn is discharged from hospital and a child protection worker has undertaken to investigate and assess the parenting capacity of the child's primary caregiver, the child protection worker should confirm with hospital staff that an appointment has been made for the child to be seen by a health care provider, and the child protection worker should subsequently confirm with the health care provider that the appointment was kept.

Rationale for Recommendation #34

In this case, there was no follow-up by a physician. The hospital and the Catholic Children's Aid Society had a different understanding as to who the follow-up physician was. No verification was made to ensure that the mother actually took baby Jordan to the doctor. Mandatory verification is not necessary for all mothers, but only mothers who are identified as high risk.

Explanation:

This is a critical recommendation. It is clear that there was not proper understanding of who was going to look after this child medically once it was discharged from hospital.

RECOMMENDATION #35

We the jury recommend, that hospitals and child protection agencies should review policies to ensure clear communication between hospital staff and child protection workers. Input from the hospital staff regarding concerns should be fully communicated and assessed by the child protection agency. Fact to face meetings by the assigned child protection worker and all

relevant hospital staff should be encouraged and arranged by the child protection worker when hospital staff raises concerns. Information flow should be both ways. In addition to obtaining all relevant information from hospital staff, child protection agencies should inform staff of the relevant issues (for example: transportation issues and eating disorders) which may be important for the baby's care while in the hospital.

Rationale for Recommendation #35

There is evidence that the social worker did not hold meetings with the nurses and did not review hospital records.

Explanation:

Evidence in this case indicated that there was not full communication and discussion held between the C.A.S. worker and the nursing staff before the child was discharged from hospital and that this type of meeting is extremely important for it to properly assess whether the case is at high risk or not.

RECOMMENDATION #36

We the jury recommend, that it be suggested that each Hospital Board delegate an individual who will be responsible to look at the recommendations submitted by the jury and the feasibility of their implementation. This person could also be responsible for on-going education, monitoring of pre and post-natal discharge policies, and maintaining contact with relevant community groups in their geographic area.

Rationale for Recommendation #36 – None given.

Explanation -- Self-explanatory.

RECOMMENDATION #37

We the jury recommend, that when hospital staff make a referral to a Children's Aid Society regarding a child, the hospital will automatically involve the Hospital Social Worker. The social worker will remain involved with the nursing staff to resolve problems as they arise in the hospital, along with:

- *Act a s liaison between hospital, family and the Children's Aid Society, to share and provide information as required and/or permitted by law;*
- *Assist in any required follow-up intervention when appropriate;*
- *Will remain involved with the family care while the baby and/or mother remain in the hospital, even when a referral has been made to a Child Welfare Agency*

In situations where there is no Hospital Social Worker one person should be assigned to discharge the facilitative role.

Rationale for Recommendation #37

Where a child, particularly a newborn infant, is transferred from the medical system to the child welfare system, there is need to ensure that the move occurs with optimal communication.

Explanation:

When a child particularly a newborn infant is being transferred from a medical system to a child welfare system there needs to be a full dialogue between the two different professions. The Jury feel that the hospital social worker being knowledgeable of both the medical system and the child welfare system would be an excellent source person to ensure the necessary exchange of important information take place.

RECOMMENDATION #38

We the jury recommend, that manufacturers of all baby formula should put on the labels of their product a warning of the danger of diluting the formula without the specific recommendations of a physician. This warning to be placed in a conspicuous place on the label.

Rationale for Recommendation #38

The mother of baby Jordan was diluting the formula to such a degree that any nourishment supplied was insufficient for him to survive on.

Explanation:

Renee Heikamp admitted that she never read the instructions on the formula can and just diluted the formula by putting two ounces of formula in the bottle and filling up the bottle with tap water. Although the Jury have made this recommendation I do not know how practical it really is. There was absolutely no evidence at the Inquest that Renee Heikamp had any difficulty in reading.

RECOMMENDATION #39

We the jury recommend, that any mother discharged from hospital intending to breastfeed, but where the feeding has not be established, are seen within 24-48 hours by a lactation consultant. Also that signs of infant hydration and successful breastfeeding be taught in the pre and post-natal periods, along with the proper hygiene care of breasts. The appointment for

the lactation consultant be included in the standardized discharge summary, and where appropriate, the same verification system as for doctors visits be in place:

- *Information regarding breast or bottle feeding difficulties, and how to recognize when feeding is going well and signs of distress;*
- *Twenty-four (24) hour availability of hospital nursery nurses;*
- *Twenty-four (24) hour telephone number for breastfeeding information and assistance.*

Rationale for Recommendation #39

Proper care of a newborn infant can only be provided if those responsible for that care are aware of the infant's needs and are capable of meeting those needs.

Explanation -- Self-explanatory.

RECOMMENDATION #40

We the jury recommend, that the "Healthy Babies, Healthy Children" Postpartum screening tool should be completed and forwarded to Public Health for all children regardless of consent. Sufficient funding should be allocated to the "Health Babies, Healthy Children" program to allow the implementation of the entire program's phases.

Rationale for Recommendation #40

Evidence was given that the volume is often too great to make all of the calls within forty-eight (48) hours of discharge and Public Health does not have sufficient nurses to staff the program due to nursing shortages in the province. Increased funding for staffing is necessary to ensure continuance and full implementation of this vital program. The program should be mandatory and home visits should be implemented in all cases where significant risk factors are identified.

Explanation:

This Healthy Baby Post-Partum Screen and the program was presented in such an impressive manner at this Inquest that the Jury feel obviously even more use should be made of the program. This certainly deserves further evaluation but I personally feel one should ensure that there are not duplication of services. However, if there is any doubt about who is going to monitor a child afterwards I would agree with the Jury that a Health Baby, Healthy Children Program is already in place and performs an excellent service.

RECOMMENDATION #41

We the jury recommend, that all shelter workers should be precise in describing to outside agencies the services that their shelter can provide. In particular, if a shelter employs persons who have nursing experience but did not employ those persons to deliver nursing services, then the shelter's workers must be sure not to say anything which might create the mistaken impression that the shelter offers nursing services.

Rationale for Recommendation #41

Two (2) shelter workers, with nursing experience, were hired as counselors but the mistaken impression was given that nursing services were offered. This created a false security with the social worker and mother of baby Jordan.

Explanation:

Much evidence at the Inquest dealt with what services the shelter said it could provide. There were difference of opinion in terms of what could be provided and therefore the Jury recommended that there be clear and precise understanding of the services the shelter would provide. In this case there were two (2) counselors on staff at the Aduhyaun Shelter who had nursing experience but were not hired as nurses. There certainly was confusion as to how this was interpreted by Renee Heikamp and the C.A.S. social worker.

RECOMMENDATION #42

We the jury recommend, that programs like "Healthy Connections – Community Programs" which reach out to various communities within Toronto by medical practitioners, continue to be recognized and supported by all levels of government.

Rationale for Recommendation #42

Evidence revealed a practical medical outreach program which is already in place and which has worked well.

Explanation:

Evidence was presented that Aduhyaun now has a connection with the family practice unit at the Western Division of Toronto Hospital and that this practical medical outreach program is extremely valuable particularly to the shelter communities.

RECOMMENDATION #43

We the jury recommend, that the Public Health Departments and "Healthy Babies, Healthy Children" programs should provide outreach on a regular basis to Youth Shelters and Women's and Family Shelters, which provide residential services to women and children to ensure provision of:

- *Health education*
- *Routine health assessment*
- *Effective linkages and referral with other medical professions*

Rationale for Recommendation #43

The special needs and circumstances of this population must be addressed in order to ensure that appropriate health care is available.

Explanation -- Self-explanatory.

RECOMMENDATION #44

We the jury recommend, that the Child Coroner's Office within one (1) year of the anniversary date of this inquest provide a report on the implementation of the above recommendations.

Rationale for Recommendation #44 – None given.

Explanation: Self-explanatory.

In closing, I would like to stress again that this document was prepared solely for the purpose of assisting interested parties in understanding the Jury's Verdict. It is worth repeating that it is not the Verdict. Likewise, many of the comments related to the evidence are my personal recollection of same and ARE NOT put forward as actual evidence. If I made any gross errors, I apologize and if this is brought to my attention I will gladly correct the error.

James T. Cairns, M.D.
Deputy Chief Coroner for Ontario