

*Yell
-2002 file
-2002-66*



Ministry of
The Solicitor
General
Ministère du
Soliciteur
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 Mississauga, Ontario
de _____
of Mississauga, Ontario
de _____
of Mississauga, Ontario
de _____
of Brampton, Ontario
de _____
of Mississauga, Ontario
de _____

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

Surname / Nom de famille: **JOBIN** | Given names / Prénom: **Stephanie**

aged **13** held at **The Land Registry Building, 7765 Hurontario Street, Crt Rm H-9, Brampton, Ontario**
agé(e) de qui a été menée à

From the **19 November** to the **17 December** 20 **02**
du a la

By **Dr. William LUCAS** Coroner for Ontario
Par coroner pour l'Ontario

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

- | | |
|--|--|
| 1. Name of deceased
Nom du (de la) défunt(e) | Stephanie Jobin |
| 2. Date and time of death
Date et heure du décès | June 20, 1998 at 11:30 am |
| 3. Place of Death
Lieu de décès | Hospital for Sick Children, Toronto |
| 4. Cause of death
Cause du décès | Hypoxic-ischemic encephalopathy secondary to
cardiopulmonary arrest associated with restraint in
the prone position for psychiatric agitation |
| 5. By what means
Circonstances entourant le décès | Undetermined |

The verdict was received on the **17** day of **December** 20 **02**
Ce verdict a été reçu par moi le

Original signed by Coroner

The Recommendations of the Stephanie Jobin Inquest

We, the jury submit the following recommendations for consideration:

Access to Resources

1. The provincial government should follow the principle of entitlement to service for all children and youth with developmental disabilities and mental health challenges. Client access to services should be available province-wide and not be primarily prioritized according to the region in which they live.

Funding

2. That the Ministry of Community, Family and Children's Services fund Children's Aid Societies for the actual cost of purchasing and/or delivering group and individual care within their respective regions instead of using a provincial average. Funding should be based on the principle of entitlement.

Continuum of Services

3. That the Ministries' of Community, Family and Children's Services, of Health and Long Term Care and, of Education create within each region, an integrated continuum of services that addresses transition periods from preschool through to adulthood, for children and youth with complex special needs including dual diagnosis. Service categories for consideration are as follows: regional accessibility; flexible, professional in-home supports; case management supports; parent relief (provided in the home); respite care (provided in residential facilities in the community); shared care (a combination of parental and foster care); full-time residential care and; timely access to education at community schools.

Regional Centers of Expert Care

4. The Ministry of Health and Long Term Care and the Ministry of Community, Family and Children's Services should support the additional development of expert assessment and treatment centers for children and youth with complex special needs and dual diagnosis, in each region of the province not currently serviced. Each



regional center should provide a range of on-going services that support community-based and residential programs including the availability of a behavioral therapy consultative service for group homes and each regional Children's Aid Society. In addition, consideration should be given to the development within these regional centers of a crisis response service.

Consultative Expert Forum

5. That the Ministry of Community, Family and Children's Services, the Ministry of Health and Long Term Care and, the Ministry of Education, establish a mechanism to create an expert, second opinion forum for exceptional cases, to provide case consultation and advice, to the entire team providing care to a child or youth. This consultation would be available in situations in which the care and treatment is not effective in achieving safe behaviour management on a continuing basis, and where the safety of the child, staff and, other children is being jeopardized. This mechanism would allow the creation of such forums on a timely basis, drawing upon professional expertise throughout the province.

This expert, second opinion forum would include the following professionals not involved directly in the case, drawn from a central list of such persons who have agreed to contribute to this resource: a facilitator, a psychiatrist with the requisite expertise, a behavioural management therapist, a psychologist, an expert in child and youth or developmental services work (with both practical and theoretical experience), a social worker, and any other appropriate experts as deemed necessary. A representative of youth in care and the Child Advocate's Office should participate in this forum as a matter of course.

The forum would be publicized and accessed according to established criteria: by the case manager, parent, legal guardian or the treatment team, or the reviewer of the Serious Occurrence Reports on restraints.

The forum may also be accessed by the Coroner or the Coroner's Pediatric Death Review Committee, as required.

Licensing

6. That the Ministry of Community, Family and Children's Services require as part of the annual licensing process, that employees of all residential facilities have on their human resources file, current qualifications with respect to training in: cardiopulmonary resuscitation, first aid and a Ministry approved behaviour management intervention training program.



7. That the Ministry of Community, Family and Children's Services review all annual Serious Occurrence Report summaries for all licensed group homes as part of the licensing review process. In addition, should client care questions be noted during the licensing review, this information should be forwarded to the appropriate Ministry Program supervisor. If required, the Child and Family Services Act should be amended to facilitate the sharing of pertinent inter-departmental information.

Plans of Care

8. To all residential service providers, Plans of Care need to be developed and communicated within a supportive and positive, goal-oriented context. The "whole child as a person, with strengths and unique qualities" is paramount.
9. To all residential service providers, Plans of Care should include individualized behaviour management intervention strategies that are consistent amongst all care providers (day treatment and residential) for that child/youth. The behaviour management intervention portion of the Plan of Care should be in a standardized format, province-wide. Thresholds, indicating the need for a case conference or an emergency/crisis response, should be indicated for each individual child/youth. All deviation from the Plan of Care must be documented. This format will assist with client care, employee initiative, licensing and, quality assurance.

Quality Assurance

10. That licensed residential service providers develop a quality assurance program to evaluate adherence to policies, procedures and standards of care. Results of the quality assurance reviews should be documented and reported to: all employees and residents, and be made available to placing agencies.
11. The Ministry of Community, Family and Children's Services should consider their funding and consultative role in the development of quality assurance, as the goal would be to incorporate quality assurance into the licensing process for all residential service providers.

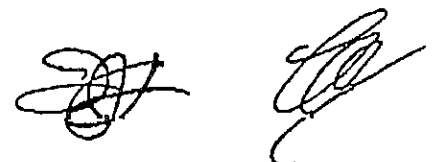


Restraints

12. All residential and day treatment providers should review the significant dangers of 'prone restraints' with staff. The training should be designed to promote and strengthen de-escalation skills and to teach physical intervention techniques that avoid the prone restraint position.
13. All licensed residential facilities must record in their policies and procedures, the consequences of staff failing to comply with the approved behaviour management intervention program. Failure to comply would be identified through supervision, Serious Occurrence Reports, residence and CAS agency reporting mechanisms, and quality assurance monitoring.
14. All licensed residential care facilities, day treatment and applicable Ministry of Education programs be legislated to develop an internal "Restraint Review Committee". Terms of reference should include the expectation that all training be evidence based; that evaluations of knowledge and skill be competence based; that the committee has a clear mandate to monitor restraint use and take appropriate corrective action.
15. Following the implementation of the April, 2003 restraint regulations of Serious Occurrence Reports, the Ministry of Community, Family and Children's Services consider the development of standardized restraint and crisis response thresholds for incorporation into policy. We recommend Ontario data and evidence-based research be the basis for this policy.
16. Where, in the opinion of the Ministry of Community, Family and Children's Services, there are reasonable concerns regarding improper use of restraints, the Ministry shall conduct a full investigation. If concerns are not alleviated following thorough investigation, the Ministry shall be required to report any reasonable concerns regarding the improper use of restraints in a licensed group home to all Children's Aid Society agencies who have children or youth placed in the licensed group home in which this concern has arisen. To acquire this level of integrative communication, legislative change and/or proclamation of current legislation is necessary.

Training and Education

17. That Children's Aid Societies ensure social workers assigned to persons with complex special needs, dual diagnosis and/or developmental disabilities have



appropriate specialized training. The training would further enable communication with respect to quality of care and, the assessment and monitoring of the plan of care for adequacy and effectiveness of child/youth services provided.

18. That University and Community Colleges in the Province of Ontario providing post-secondary education in Human Services have, as part of their curriculum, First Aid, Cardio-Pulmonary Resuscitation and an approved crisis de-escalation and intervention training program as mandatory courses within their first year program. That such training be revisited each year of study.
19. That University and Community Colleges in the Province of Ontario providing post-secondary education in Human Services have, as part of their curriculum development plan, a Panel, or Advisory Board comprised of active agency representatives (including youth in care) that will assist with insight into current field experiences and future trend indicators including the need for additional qualified staff. Planning should involve the setting of specific training and continuing education targets with particular emphasis placed on ensuring that a broad knowledge of the challenges of child and youth with developmental disabilities, combined with mental health problems (dual diagnosis), be acquired by all and that specialists be trained and supported. Consideration should be given to the regulation of standards for education and training.

Research

20. That the Ministry of Community, Family and Children's Services support Ontario-based research into the effective and safe use of restraints in general and into alternative non-intrusive methods of behaviour management. In addition, research should focus and evaluate issues pertaining to children and youth, and the effectiveness/non-effectiveness of each of the approved training curriculum(s), as well as any unknown long-term effects of use of restraints.
21. Consideration should then be given to policy endorsement of one approved behaviour management intervention program. This is to prevent program cross-training confusion and 'program drift' that could result in the use of improper or dangerous restraints in a crisis situation.



Communication

Rationale:

Throughout the Inquest proceedings there was evidence to suggest that there were many barriers to the sharing of information that may have had an adverse impact on client care. So that these issues will be addressed, for the benefit of all children and youth in care, we recommend that:

22. The *Child and Family Services Act* be amended to give the Ministry of Community, Family and Children's Services the authority to make available to all Children Aid Societies the following: serious occurrence reports, annual serious occurrence report summaries, licensing reports and any other information it deems relevant to the safety of children and youth in care, and the Office of Child and Family Service Advocacy. This information should be disclosed in a form that does not reveal the name or other personal information of individuals, except where the Ministry deems appropriate to protect the best interests of children.
23. The *Child and Family Services Act* be amended to require the Ministry of Community, Family and Children's Services to notify all CAS Agencies with a child or youth in the care of a particular licensed group home where, in the view of the Ministry, there are reasonable grounds to believe that the safety of a child or youth is at risk in that home.
24. A CAS Agency be required to notify the Ministry of Community, Family and Children's Services and other CAS Agencies where, in its view, there are concerns regarding the quality of care a child or youth is receiving in the home and/or there are reasonable grounds to suspect that the safety of a child or youth is at risk.
25. The Ministry of Community, Family and Children's Services direct, where applicable, the supervising CAS Agency worker to ensure that pertinent information regarding the ongoing status of the child or youth is being shared between all treatment providers on a regular and timely basis.
26. Absent any reasonable protection concerns, parents who have access to the child should have, on request, access to the following documents: Plans of Care and Serious Occurrence Reports from the licensed group home or Children's Aid Society agency.



27. The licensing and program supervision departments within the Ministry of Community, Family and Children's Services report to the same Deputy Minister in the hope that communication will be facilitated for the benefit of all children and youth in care.

Central Database

28. We recommend consideration be given to the formulation of a central database regarding licensed residential facilities, under the auspices of the Ministry of Community, Family and Children's Services. All information contained therein would require validation. The terms of reference defining the purpose would need to be established. Considerations for inclusion are as follows:

The Ministry should establish a quality review process for all licensed residential facilities, for the collection and compilation of all serious occurrence reports, annual serious occurrence report summaries, licensing reports, and results of investigations. The serious occurrence reports and annual serious occurrence report summaries should not make reference to the personal information of particular children. This database shall be accessible by all Ministry offices within the province and all provincial CAS Agencies.

Independent Autonomous Regulatory Body

29. Should recommendation # 28 (central database) not be deemed feasible after comprehensive participant collaboration, consideration should then be given by the Ministry of Community, Family and Children's Services to the formation of an independent, autonomous regulatory body that would encompass:
- responsibility for quality assurance,
 - licensing of residential facilities,
 - ongoing development and revision of service delivery standards and evidenced-based practices focused on client outcomes and results,
 - provision of direction to individual residential care providers on service delivery and agency management practices, and improvements that may be required to meet provincial standards,
 - analysis and further exploration of serious occurrences and, where appropriate, the development of strategies for corrective action,



- investigation of concerns regarding care and services delivered by the program to residents, and appropriate corrective measures,
- setting of standards for staff qualifications at both the front line, supervisory and management levels and training expectations for the same and,
- annual evaluation of programs (incorporating input from agencies, parents, and the children/youth using them),

Pursuant to the suggested development of the preceding regulatory body, a clear role of the Ministry of Community, Family and Children's Services would need to be defined within the continuum of the children's services. This role would include policy development and system management focusing on legislation, direction setting, clarifying of expectations, funding, ensuring value for dollar, and empowering the Independent Autonomous Regulatory Body to set and enforce standards of care and promote Quality Assurance.

Accountability

Rationale:

We, the jury, have reviewed a number of reports and previous jury recommendations that have in large part not been addressed by the government. We forward the following recommendation for consideration in the hope that children and youth will benefit from it and that future juries will not need to re-visit prior recommendations.

30. The Ministry of Community, Family and Children's Services, Integrated Services Division, review and implement, with a view towards policy and standards development, pertinent recommendations from the following:

- *"Voices From Within: Youth Speak Out"*, with particular attention to Section five, regarding Best Practices, (April 1998),
- report from the, *"Intersectoral / Interministerial Steering Committee on Behavioural Management Interventions For Children and Youth in Residential and Hospital Settings"*, with particular attention to section 4.2, Best Practice, (March 31, 2001),
- *"Peel Region Special Needs Children Profile Review"*, (May 1, 2002).
- Inquest Recommendations; W. Edgar, *
- Inquest Recommendations; J.D. Durnford. *

*We also understand that the Minister has yet to respond to these two Inquest Recommendations.

STEPHANIE JOBIN INQUEST

VERDICT EXPLANATION

Location: Courtroom H-9, Land Registry Building,
7765 Hurontario Street, Brampton

Dates of Inquest: November 18 – December 17, 2002

Coroner's Counsel: Mr. Tyler Shuster, Peel Region Crown's Office

Investigating Officers: Det./Sgt. Frank Roselli, Det. Const. Glen Margison
Peel Regional Police

Coroner's Constable: Special Constable Marie Duff, Peel Regional Police

Court Reporter: Lisa Cumber
Halton Reporting Services
Tel: (905) 541-2747
Fax: (905) 690-7333

Parties with Standing:

1. Denis Jobin (father) represented by Jeremy Robinson, Kathleen Riggs
2. Defence for Children International (DCI) represented by Susan Fraser
3. Digs for Kids (DFK), Ron Luciano, Barry Edington, Jacqueline Hall represented by William Gilmour, M. Dhaliwal, Brian Metson
4. Lisa Johnston represented by Bruce Daley
5. Jennifer Gibbs represented by Maureen Currie
6. Dr. Wehrspann represented by Chris Hubbard, Julie Slaughter
7. Children's Aid Society of Hastings represented by Daniel Wiltshire

8. Family and Children's Services of Waterloo Region represented by Randel Hamel
9. Children's Aid Society of Peel represented by Michael Hartrick

In this document I have written a brief summary of the circumstances surrounding Stephanie Jobin's death, as well as a brief synopsis of the issues explored at the inquest. Where it was felt to be of potential assistance, I have also commented on my understanding of the reasons behind the jury's recommendations. I wish to stress that it comprises my own interpretation of the evidence and of the jury's reasoning. It is not intended to replace the actual evidence presented to the jury, but is provided to assist the reader in interpreting the context in which their verdict and recommendations were made, so that those recommendations can be better understood. This verdict explanation is not intended to replace the jury's verdict.

Brief Summary of the Circumstances of the Death and Inquest:

Stephanie Jobin was born November 11, 1984 in Sudbury. Her mother experienced complications during the pregnancy, including Toxemia and a prolonged labour and delivery. At three months of age she was admitted to hospital for 'failure to thrive', and as she grew she lagged progressively behind in developmental milestones. By the age of four years she was noted to be hyperactive, aggressive and would frequently bite herself and others. Trials with medications were not successful in controlling her behaviours.

Her parents separated in 1985, and officially divorced in 1988. Her mother had moved back to her hometown of Bancroft, Ontario after the separation with her spouse, and continued to attempt to care for Stephanie. In 1990, Stephanie entered school in a Special Education Program, and in 1991 (age 6) she was diagnosed with Autism and Mental Retardation. Despite further trials with medications, her aggressive behaviour continued to increase. In September 1993 she was admitted to a Kingston hospital on an emergency basis because her family was unable to control her aggressiveness and self-inflicted injuries.

She was subsequently transferred to the Beechgrove Children's Centre, Kingston, in October, 1993 for further psychiatric assessment. She presented with aggressive behaviours directed towards herself and others, impaired social skills, difficulties with bedwetting, voluntarily defecation and smearing of feces, and sleep disturbance. At time of discharge from the Centre in December, 1993 the diagnoses included: Pervasive Developmental Disorder (PDD) with Autistic features, Attention Deficit Disorder with Hyperactivity (ADHD), motor tic disorder, mother-child attachment disorder, functional enuresis and encopresis.

Stephanie's mother continued to struggle with managing her, while seeking financial assistance to place her in a residential setting. After this assistance was denied, her mother approached the Hastings Children's Aid Society on August 31, 1994 (age 9 years) and abandoned Stephanie to their care so that the child would receive the special services she required. Stephanie was placed in a group home in the Belleville area.

Within months, it was apparent that Stephanie's aggressive behaviours were more challenging than the group home staff could manage, and that community resources to meet her complex needs were lacking. Hastings CAS began a search to locate a comprehensive in-patient assessment/treatment centre that could address Stephanie's demanding behaviours. After considerable difficulty they were able to convince the Parent Child Resource Institute (CPRI) of London, Ontario to take her for an assessment, and she was admitted in March, 1995 (age 10 years).

CPRI is a multidisciplinary, in-patient assessment facility specializing in children with complex developmental and psychiatric diagnoses. What was initially intended to be a 2-month inpatient assessment period at CPRI lasted over 8 months, due in part to the complexity of her problems, and also to the lack of suitable resource in the community able to manage her adequately.

The psychiatrist responsible for her care ultimately concluded that Stephanie had a multiple complex developmental disorder, including mild to moderate mental retardation, features of autism, and borderline psychosis of childhood. He also concluded that she was one of the most disturbed children he had ever encountered at CPRI.

Stephanie's treatment program at CPRI included trials of multiple antipsychotic medications. In addition, CPRI developed a plastic 'bucket restraint system' to protect against injury to staff members who worked with her. CPRI also recommended the use of a specially designed semi-circular table and chair unit that created space between Stephanie and others in her immediate vicinity. A unique 'strip suit' was devised to prevent Stephanie from injuring herself by probing bodily orifices, and to prevent fecal smearing.

Tragically, Stephanie's mother died rather suddenly in November 1995. Shortly thereafter, Stephanie was placed at a group home in Brampton called Digs for Kids (DFK), which was the only home that could be found that was willing to take her. This placement commenced on December 6th, 1995, and unfortunately, Stephanie was not able to obtain any formal schooling during the 1996 calendar year.

Stephanie became a Crown Ward of the Children's Aid Society on September 25th, 1996. In January 1997 she commenced a school program under the direction of TREADD (Treatment, Research and Education for Autism and Developmental Disorders), a multidisciplinary assessment centre operated under the auspices of the Ministry of Community, Family and Children's Services (MCFCS). TREADD made modifications to the CPRI-recommended program in an effort to control Stephanie's aggressive behaviours.

Despite this, Stephanie's aggressions continued to escalate steadily through 1998. In early June, Stephanie's primary caseworker at DFK left to pursue other career opportunities. During the next two weeks, reacting to this loss, Stephanie's aggressions became much worse. During this time she required restraint on a daily basis, averaging approximately 100 minutes per day. On June 17th Stephanie required restraining six times at school for leaving her work area and attacking her instructors. During the 4.5 hours spent at school that morning, she was restrained for a total of almost two hours.

She returned to DFK at approximately 2:30 PM and immediately verbalized to staff that she was having a bad day. Immediately she continued to exhibit aggressive behaviours including scratching, hair pulling, biting, kicking, and lunging at staff. At 4 PM she was administered her medication (chlorpromazine 50 mg), and staff attempted to redirect her and engage her in her after-school social programs. However, her aggressions continued to escalate. At 7 PM she was given a second dose of chlorpromazine 50 mg, with a further repeat (PRN) dose at 7:30 PM. (A toxicology analysis later determined that this medication played no role in her subsequent cardiorespiratory arrest.)

At approximately 8:10 PM she attacked one staff member, pulling her to the floor. Three staff members then attempted to engage Stephanie in a restraint to control her. During the struggle, Stephanie ended up on the floor in the prone position. As Stephanie continued to struggle and aggressively attack, one staff member straddled her legs in an attempt to control them, while the other placed a deflated bean bag chair over Stephanie's upper body, straddling her and holding her arms.

Over the next twenty minutes, Stephanie continued to struggle, at times forcing staff from their positions. Suddenly, she became motionless and stopped breathing. Immediately sensing something was wrong, the two staff members screamed for assistance to call 911, and began to administer CPR. In their state of anxiety and panic, it was not clear how effectively the CPR was rendered.

Emergency responders subsequently took over and transferred Stephanie to the local community hospital. After a period of stabilization she was transferred to a large, tertiary centre's critical care unit. Over the following three days it became apparent that Stephanie had sustained irreparable brain damage. On June 20th, 1998 she was declared brain dead. Her eyes, heart and kidneys were donated for transplantation purposes.

The inquest heard from a total of 22 witnesses over a period of 14 sitting days. Forty-six exhibits were entered for the jury's consideration. Deliberations took place over 5 days before the jury returned with their verdict.

Verdict of Coroner's Jury:

Name: Stephanie Jobin

Date of Death: June 20, 1998, at 11:30 AM

Place of Death: Hospital for Sick Children, Toronto

Cause of Death: Hypoxic Ischemic Encephalopathy
secondary to cardiopulmonary arrest associated with
restraint in the prone position for psychiatric agitation

By what means: Undetermined

Coroner's Comment:

From the evidence presented in this inquest, only 3 options were open to the jury to consider for the manner of death - accident, homicide or undetermined. 'Accident' was defined as an occurrence, incident, or event that happens without foresight or expectation. 'Homicide' was defined as the action of a human being killing another human being. 'Undetermined' was to be considered where there was inadequate evidence to draw any conclusions, or if the evidence pointed fairly equally to two or more classifications, or if the jury members remained widely divided in their views.

The jury heard compelling arguments in support of both accident and homicide. From their verdict, I must include that they felt that the evidence pointed fairly equally to the two classifications, or that they remained widely divided in their opinions.

Recommendations

Access to Resources

1. The provincial government should follow the principle of entitlement to service for all children and youth with developmental disabilities and mental health challenges. Client access to services should be available province-wide and not be primarily prioritized according to the region in which they live.

Coroner's Comment:

The jury has accepted the position put forward at the inquest that all individuals in this province with developmental disability and/or mental health challenges should be entitled to certain services. There was evidence that these specialized services tend to be rather limited in availability, and where they do exist, priority is given to residents of their own region.

Funding

2. That the Ministry of Community, Family and Children's Services fund Children's Aid Societies for the actual cost of purchasing and/or delivering group and individual care within their respective regions instead of using a provincial average. Funding should be based on the principle of entitlement.

Coroner's Comment:

Evidence was presented that the Ministry of Community, Family and Children's Services (MCFCS) provided funding to CASs of approximately \$168 per day of care in group homes in 2001/02. The funding formula was based on the provincial average, mixing parent-model group homes (\$65-\$90 per day) with staff-operated group homes (\$160-\$450 per day). For one of the CAS agencies represented at the inquest, the average group home care cost per day for the same time period was approximately \$242. Thus there was a deficit of close to \$74 per day for each child in care in a group home setting.

Continuum of Services

3. That the Ministr(y) of Community, Family and Children's Services, (Ministry) of Health and Long Term Care, and (Ministry) of Education create within each region, an integrated continuum of services that addresses transition periods from preschool through to adulthood, for children and youth with complex special needs including dual diagnosis. Service categories for consideration are as follows: regional accessibility; flexible, professional in-home supports; case management supports; parent relief (provided in the home); respite care (provided in residential facilities in the community); shared care (a combination of parental and foster care); full-time residential care; and timely access to education at community schools.

Coroner's Comment:

Evidence was presented that children and youth with complex special needs, and their families, must have a variety of services readily available to them. The complexity and sophistication of these services requires an integrated approach and cooperation from

several Ministries, and must support the child through all stages of life: from preschool to school age, through the transition to adolescence, and from adolescence to adulthood. Currently, programs often tend to be deficient at critical stages of the child's or youth's development, and therefore do not provide a smooth continuum of services.

Regional Centers of Expert Care

4. The Ministry of Health and Long Term Care and the Ministry of Community, Family and Children's Services should support the additional development of expert assessment and treatment centers for children and youth with complex special needs and dual diagnosis, in each region of the province not currently serviced. Each regional center should provide a range of on-going services that support community-based and residential programs including the availability of a behavioural therapy consultative service for group homes and each regional Children's Aid Society. In addition, consideration should be given to the development within these regional centers of a crisis response service.

Coroner's Comment:

Evidence was presented that the only existing expert assessment and treatment centers in the province are TREADD and CPRI. Due to their locations and limited bed availability, access to these invaluable resources is very limited and waiting lists are lengthy. The jury is suggesting that more centres similar to those in existence should be developed throughout the province to provide specialize services such as psychiatry, psychology, medical services, assessment and diagnostic services.

By providing a behavioural therapy consultative service, particularly to those individuals previously assessed in their facilities, they would be able to promote continuity and consistency of care out in the community. A crisis response service would enable a rapid intervention in residential settings in those situations where group home care providers were experiencing difficulties with implementation of care plans.

Consultative Expert Forum

5. That the Ministry of Community, Family and Children's Services, the Ministry of Health and Long Term Care, and the Ministry of Education establish a mechanism to create an expert, second opinion forum for exceptional cases to provide case consultation and advice to the entire team providing care to a child or youth. This consultation would be available in situations in which the care and treatment is not effective in achieving safe behaviour management on a continuing basis, and where the safety of the child, staff and, other children is being jeopardized. This mechanism would allow the creation of such forums on a timely basis, drawing upon professional expertise throughout the

province.

This expert, second opinion forum would include the following professionals not involved directly in the case, drawn from a central list of such persons who have agreed to contribute to this resource: a facilitator, a psychiatrist with the requisite expertise, a behavioural management therapist, a psychologist, an expert in child and youth or developmental services work (with both practical and theoretical experience), a social worker, and any other appropriate experts as deemed necessary. A representative of youth in care and the Child Advocate's Office should participate in this forum as a matter of course.

The forum would be publicized and accessed according to established criteria: by the case manager, parent, legal guardian or the treatment team, or the reviewer of the Serious Occurrence Reports on restraints.

The forum may also be accessed by the Coroner or the Coroner's Pediatric Death Review Committee, as required.

Coroner's Comment:
Self-explanatory.

Licensing

6. That the Ministry of Community, Family and Children's Services require as part of the annual licensing process, that employees of all residential facilities have on their human resources file, current qualifications with respect to training in: cardiopulmonary resuscitation, first aid and a Ministry approved behaviour management intervention training program.
7. That the Ministry of Community, Family and Children's Services review all annual Serious Occurrence Report summaries for all licensed group homes as part of the licensing review process. In addition, should client care questions be noted during the licensing review, restraints information should be forwarded to the appropriate Ministry Program supervisor. If required, the Child and Family Services Act should be amended to facilitate the sharing of pertinent inter-departmental information.

Coroner's Comment:

There was a considerable body of evidence presented that the MCFCS annual licensing process for residential group homes has traditionally assessed only minimal standards. It has not included a review of staff personnel files to determine that certain minimum training requirements have been met. Once new regulations are enacted in April 2003, and Serious Occurrence Reports will be required for all instances where restraints are utilized, a review of these should be required as part of the license renewal process.

The Plans of Care

8. To all residential service providers, Plans of Care need to be developed and communicated within a supportive and positive, goal-oriented context. The “ whole child as a person, with strengths and unique qualities” is paramount.
9. To all residential service providers, Plans of Care should include individualized behaviour management intervention strategies that are consistent amongst all care providers (day treatment and residential) for that child/youth. The behaviour management intervention portion of the Plan of Care should be in a standardized format, province-wide. Thresholds, indicating the need for a case conference or an emergency/crisis response, should be indicated for each individual child/youth. All deviation from the Plan of Care must be documented. This format will assist with client care, employee initiative, licensing and quality assurance.

Coroner's Comment:

In August 1999 the MCFCS (Ministry of Community and Social Services as it was then known) published a draft document entitled “Standards for Service Providers Who Support People with Challenging Behaviours” that outlined several principles and standards of practice for support strategies when dealing with challenged individuals. There is an emphasis on support strategies that protect an individual's rights, have a positive focus for change, frequently assess effectiveness, monitor interventions and limit the use of intrusive methods.

Residential service providers must recognize each individual's uniqueness, thereby creating an individualized Care Plan that is long-term, focussed on the individual's needs, and consistent across the continuum of care, utilizing the above noted principles. Standardization of approach across all sectors, and clear indicators of the need for alternate interventions would be very helpful, both to the clients and in assessing quality of care by providers.

Quality Assurance

10. That licensed residential service providers develop a quality assurance program to evaluate adherence to policies, procedures and standards of care. Results of the quality assurance reviews should be documented and reported to: all employees and residents, and be made available to placing agencies.
11. The Ministry of Community, Family and Children's Services should consider their funding and consultative role in the development of quality assurance, as the goal would be to incorporate quality assurance into the licensing process for all residential service providers.

Coroner's Comment:

The need to develop and/or enhance quality assurance programs was a central theme throughout the inquest. Although many residential care facilities may have documented policies and procedures, it is unclear whether there are any mechanisms in place to assess their effectiveness or to ensure compliance in the interest of providing highest quality care to the clients.

The MCFCS must take a more proactive and leading role in the development of quality assurance programs. This includes providing adequate funding to ensure effective programs exist in the group homes, and ultimately would require a significant enhancement of the licensing review process to incorporate a substantial quality assurance component.

Restraints

12. All residential and day treatment providers should review the significant dangers of 'prone restraints' with staff. The training should be designed to promote and strengthen de-escalation skills and to teach physical intervention techniques that avoid the prone restraint position.
13. All licensed residential facilities must record in their policies and procedures, the consequences of staff failing to comply with the approved behaviour management intervention program. Failure to comply would be identified through supervision, Serious Occurrence Reports, residence and CAS agency reporting mechanisms, and quality assurance monitoring.
14. All licensed residential care facilities, day treatment and applicable Ministry of Education programs be legislated to develop an internal "Restraint Review Committee". Terms of reference should include the expectation that all training be evidence based; that evaluations of knowledge and skill be competence based; that the committee has a clear mandate to monitor restraint use and take appropriate corrective action.
15. Following the implementation of the April, 2003 restraint regulations of Serious Occurrence Reports, the Ministry of Community, Family and Children's Services consider the development of standardized restraint and crisis response thresholds for incorporation into policy. We recommend Ontario data and evidence-based research be the basis for this policy.
16. Where, in the opinion of the Ministry of Community, Family and Children's Services, there are reasonable concerns regarding improper use of restraints, the Ministry shall conduct a full investigation. If concerns are not alleviated following thorough investigation, the Ministry shall be required to report any reasonable concerns

regarding the improper use of restraints in a licensed group home to all Children's Aid Society agencies who have children or youth placed in the licensed group home in which this concern has arisen. To acquire this level of integrative communication, legislative change and /or proclamation of current legislation is necessary.

Coroner's Comment:

The use of prone restraints is a practice clearly fraught with dangers, as outlined in a 1995 memorandum from the Chief Coroner issued to all policing services, general and psychiatric hospitals, and correctional institutions. Unfortunately the contents of this memo were not shared fully with service providers working under the CFSA or MCFCS until after February 2000. All caregivers who may be required from time to time to utilize restraints must be aware of this concern.

At the time of Stephanie's death, staff in the group home had never received any information outlining the risks and dangers of prone restraints. The restraint used by the staff in an effort to control Stephanie's aggressive behaviour was not one that had been taught or sanctioned by the Crisis Prevention Institute (CPI).

The MCFCS has recently developed a Six Point Action Plan regarding physical restraints, and all program staff in licensed children's residences must be trained in the use of physical restraints and alternative behaviour management interventions using a ministry-approved training program. Compliance is required by the effective date of new regulations under section 70 of the Child and Family Services Act (CFSA), April 1, 2003.

Four training programs have been selected by the ministry to provide this training. They include: Therapeutic Crisis Intervention (TCI), Understanding and Managing Aggressive Behaviour (UMAB), Prevention and Management Of Aggressive Behaviour (PMAB), and Nonviolent Crisis Intervention (CPI).

Historically, there has been no expectation that post-course competence must be demonstrated in the methodologies taught regarding behaviour management intervention or application of physical restraints. There has also been little study of the complications or potential long-term consequences of use of restraints. Further research in this area is required. This information could be utilized by Restraint Review Committees to evaluate staff performance and effectiveness, as well as by the MCFCS in setting standards for the future.

Training and Education

17. That Children's Aid Societies ensure social workers assigned to persons with complex special needs, dual diagnosis and/or developmental disabilities have appropriate specialized training. The training would further enable communication

with respect to quality of care and, the assessment and monitoring of the plan of care for adequacy and effectiveness of child/youth services provided.

18. That University and Community Colleges in the Province of Ontario providing post-secondary education in Human Services have, as part of their curriculum, First Aid, Cardio-Pulmonary Resuscitation and an approved crisis de-escalation and intervention training program as mandatory courses within their first year program. That such training be revisited each year of study.
19. That University and Community Colleges in the Province of Ontario providing post-secondary education in Human Services have, thus part of their curriculum development plan, a Panel, or Advisory Board comprised of active agency representatives (including youth in care) that will assist with insight into current field experiences and future trend indicators including the need for additional qualified staff. Planning should involve the setting of specific training and continuing education targets with particular emphasis placed on ensuring that a broad knowledge of the challenges of child and youth with developmental disabilities, combined with mental health problems (dual diagnosis), be acquired by all and that specialists be trained and supported. Consideration should be given to the regulation of standards for education and training.

Coroner's Comment:

Evidence was presented that the current curriculums, particularly those available in community college programs for Child and Youth Workers, Developmental Service Workers, etc. do not adequately prepared human services workers for the challenges they will face when working in group home environments. Thus enhancements of these programs are required, and should be guided by input from experts working in the field.

Basic CPR, first aid, and crisis intervention training courses are not currently part of the undergraduate curriculum. Rather, they must be acquired, or made available to workers after they have commenced employment. There is potential for significant variability and inconsistency in training levels with this approach. Given that workers in this field historically have demonstrated a high degree of mobility, moving throughout their careers to a variety of institutions or facilities, greater consistency of training models is required, with the ultimate goal being the setting of standards, and possible regulation of these standards.

Research

20. That the Ministry of Community, Family and Children's Services support Ontario-based research into the effective and safe use of restraints in general and into alternative non-intrusive methods of behaviour management. In addition, research should focus and evaluate issues pertaining to children and youth, and the

effectiveness/non-effectiveness of each of the approved training curriculum(s), as well as any unknown long-term effects of use of restraints.

21. Consideration should then be given to policy endorsement of one approved behaviour management intervention program. This is to prevent program cross-training confusion and 'program drift' that could result in the use of improper or dangerous restraints in a crisis situation.

Coroner's Comment:

As noted above (see comment after Recommendation #16), there are currently four MCFCS approved training programs dealing with behaviour management, Crisis Intervention, and use of restraints. With different potential approaches to non-violent interventions, and different philosophies regarding the acceptability of certain restraint techniques, it is inevitable that confusion may arise. The staff members that may have been trained using different models are more apt to utilize techniques that are at variance with the policies and procedures of a particular institution or facility.

Further research is required, and the results of these studies may be of assistance in determining a preferred, single training model for approval by MCFCS.

Communication

Rationale:

Throughout the Inquest proceedings there was evidence to suggest that there were many barriers to the sharing of information that may have had an adverse impact on client care. So that these issues will be addressed, for the benefit of all children and youth in care, we recommend that:

22. The *Child and Family Services Act* be amended to give the Ministry of Community, Family and Children's Services the authority to make available to all Children's Aid Societies the following: serious occurrence reports, annual serious occurrence report summaries, licensing reports and any other information it deems relevant to the safety of children and youth in care, and the Office of Child and Family Service Advocacy. This information should be disclosed in a form that does not reveal the name or other personal information of individuals, except where the Ministry deems appropriate to protect the best interests of children.
23. The *Child and Family Services Act* be amended to require the Ministry of Community, Family and Children's Services to notify all CAS Agencies with a child or youth in the care of a particular licensed group home where, in the view of the Ministry, there are reasonable grounds to believe that the safety of a child or youth is at risk in that home.

24. A CAS Agency be required to notify the Ministry of Community, Family and Children's Services and other CAS Agencies where, in its view, there are concerns regarding the quality of care a child or youth is receiving in the home and/or there are reasonable grounds to suspect that the safety of a child or youth is at risk.
25. The Ministry of Community, Family and Children's Services direct, where applicable, the supervising CAS Agency worker to ensure that pertinent information regarding the ongoing status of the child or youth is being shared between all treatment providers on a regular and timely basis.
26. Absent any reasonable protection concerns, parents who have access to the child should have, on request, access to the following documents: Plans of Care and Serious Occurrence Reports from the licensed group home or Children's Aid Society agency.
27. The licensing and program supervision departments within the Ministry of Community, Family and Children's Services report to the same Deputy Minister in the hope that communication will be facilitated for the benefit of all children and youth in care.

Coroner's Comment:

The need for improved communication and sharing of information was another central theme of this inquest. One of the CAS agencies participating in the inquest had removed children in their care from DFK because of concerns regarding the programs provided to those children. The MCFCS was aware of those concerns, but was unwilling or unable, due to privacy issues, to share any information with other CAS agencies that had children placed in the same group homes. Had that information been available to the CAS agency with wardship of Stephanie, a more comprehensive review might have taken place prior to placing her at DFK.

It was clear from the evidence presented that information is readily available, but is not shared between the MCFCS and all CASs who might have an interest in it. Likewise, information is not necessarily shared readily between different divisions of the MCFCS, or between different treatment providers, all potentially to the detriment of the child's care. The jury believes these communication failures must be addressed.

Central Database

28. We recommend consideration be given to the formulation of a central database regarding licensed residential facilities, under the auspices of the Ministry of Community, Family and Children's Services. All information contained therein would require validation. The terms of reference defining the purpose would need to be established. Considerations for inclusion are as follows:

The Ministry should establish a quality review process for all licensed residential facilities, for the collection and compilation of all serious occurrence reports, annual serious occurrence report summaries, licensing reports, and results of investigations. The serious occurrence reports and annual serious occurrence report summaries should not make reference to the personal information of particular children. This database shall be accessible by all Ministry offices within the province and all provincial CAS Agencies.

Coroner's Comment:

CAS agencies historically have had to rely on their own sources, information and initiatives when determining a suitable placement for children under their care. Although a considerable database of information is available, it has not been formally centralized in a readily accessible location for use by all CASs and the MCFCS. This would greatly enhance the ability of CASs to appropriately assess the suitability of any residential facility for a particular child's placement.

Information available in this database must be validated through an appropriate process to ensure that it is fair and objective.

Independent Autonomous Regulatory Body

29. Should recommendation # 28 (central database) not be deemed feasible after comprehensive participant collaboration, consideration should then be given by the Ministry of Community, Family and Children's Services to the formation of an independent, autonomous regulatory body that would encompass:

- responsibility for quality assurance,
- licensing of residential facilities,
- ongoing development and revision of service delivery standards and evidenced-based practices focused on client outcomes and results,
- provision of direction to individual residential care providers on service delivery and agency management practices, and improvements that may be required to meet provincial standards,
- analysis and further exploration of serious occurrences and, where appropriate, the development of strategies for corrective action,
- investigation of concerns regarding care and services delivered by the program to residents, and appropriate corrective measures,

- setting of standards for staff qualifications at both the front line, supervisory and management levels and training expectations for the same and,
- annual evaluation of programs (incorporating input from agencies, parents, and the children/youth using them).

Pursuant to the suggested development of the preceding regulatory body, a clear role of the Ministry of Community, Family and Children's Services would need to be defined within the continuum of the children's services. This role would include policy development and system management focusing on legislation, direction setting, clarifying of expectations, funding, ensuring value for dollar, and empowering the Independent Autonomous Regulatory Body to set and enforce standards of care and promote Quality Assurance.

Coroner's Comment:

This recommendation is fairly self-explanatory. As noted above, the MCFCS has an annual licensing process that addresses only minimum standards. This does not adequately address a comprehensive quality assurance process that would encompass all of the elements included in this recommendation. If the MCFCS does not have the resources to assume the mandate of quality assurance, an independent agency should be considered for this purpose.

Accountability

Rationale:

We, the jury, have reviewed a number of reports and previous jury recommendations that have in large part not been addressed by the government. We forward the following recommendation for consideration in the hope that children and youth will benefit from it and that future juries will not need to re-visit prior recommendations.

30. The Ministry of Community, Family and Children's Services, Integrated Services Division, review and implement, with a view towards policy and standards development, pertinent recommendations from the following:
- "Voices From Within: Youth Speak Out", with particular attention to Section five, regarding Best Practices, (April 1998),
 - report from the, "Intersectoral / Interministerial Steering Committee on Behavioural Management Interventions For Children and Youth in Residential and Hospital Settings", with particular attention to section 4.2, Best Practice, (March 31, 2001),
 - "Peel Region Special Needs Children Profile Review", (May 1, 2002).
 - Inquest Recommendations; W. Edgar, *

- Inquest Recommendations; J.D. Durnford. *

*We also understand that the Minister has yet to respond to these two Inquest Recommendations.

Coroner's Comment:

Many of the themes, issues and concerns identified at this inquest into the death of Stephanie Jobin have been raised several times in the past in various forums and reports. The issues of training, need for standards, and research into best practices have been previously identified and published. Inquests have identified the need for a continuum of services for special needs children and youth, including in-home supports, supportive school programs, respite services, specialty assessment centres that include residential services, etc.

Other areas where issues have been identified and recommendations made include, but are not limited to:

- *the need to enhance the licensing process for residential care settings to incorporate an assessment of quality of programs;*
- *the suggestion to establish a regulatory body to oversee licensing and quality assurance;*
- *the need to enhance communication linkages for dissemination and sharing of information between the MCFCS and placing agencies;*
- *the suggestion to develop a centralized database of information regarding concerns identified in provision of care, that would be accessible to all placing agencies;*
- *the need for adequate funding to ensure quality programs and ongoing training of staff;*
- *the need for mandatory CPR and first-aid training for caregivers.*

By making this recommendation, it is my belief that the jury is both frustrated and concerned by the government's apparent lack of response to date, to recommendations that would appear to offer reasonable and practical solutions to a variety of issues that repeatedly arise in the context of special needs children and youth.

In closing I would stress once again that this document has been prepared solely for the purpose of assisting the reader in understanding the inquest jury's verdict and recommendations. It does not replace the verdict and recommendations, but rather consists of my comments and recollections of the evidence presented, on which I believe the jury based their conclusions. Should any party feel that my recollection or interpretation has been incorrect or misrepresented, kindly bring the matter to my attention so that the error might be appropriately corrected.

Respectfully submitted,

William J. Lucas

William J. Lucas, MD CCFP
Regional Supervising Coroner
Central Region

