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

(93) 14562

We / Nous soussignés,

	of / de	Etobicoke
	of / de	Toronto
	of / de	Etobicoke
	of / de	Scarborough
	of / de	Scarborough

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

Surname / Nom de famille	Given names / Prénom
CARPENTER	Trish

aged / âgé(e) de 14 years held at / qui a été menée à 15 Grosvenor Street, Toronto

on the / le 1,2,3,4,5,8,9,10,11 & 12th day(s) of / (du/au) February 19 93

by / par M. Milton M.D. Coroner for Ontario, / 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): Patricia (Trish) Carpenter
2. Date and time of death / Date et heure du décès: September 25th, 1992; 08:50
3. Place of death / Lieu du décès: 205 Yonge Street, Toronto, Ontario
4. Cause of death / Cause du décès: Asphyxiation
5. By what means / Circonstances entourant le décès: Caused by the victim being inverted in a 22 by 23 inch hole, 72 inches in depth, with a near toxic alcohol content.

VERDICT OF CORONER'S JURY

Based on the evidence heard at this inquest, we the jury conclude that the nature of Patricia (Trish) Carpenter's death is suspicious. However, there is insufficient evidence to conclude that her death is a homicide.

We the jury, unanimously make the following recommendations which may assist in the prevention of future deaths of this nature. Our recommendations are summarized under three general categories, which include: Social Service Support, Construction Safety, and Police Investigative Procedures

(Continue on reverse side if necessary / Continuer au verso si nécessaire)

This verdict was received by me this / Ce verdict a été reçu par moi le 12th day of / February 19 93

M. D. Milton M.D.

Signature of Coroner / Signature du coroner

Distribution: Original - Regional Coroner for forwarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en chef
Copy - Crown Attorney / Copie - Procureur de la Couronne

We wish to make the following recommendations: / Nous souhaitons faire les recommandations suivantes:

SOCIAL SERVICES

1.1 That the Child and Family Services Act, Section 37 be amended to provide police with aurthority to apprehend youth under the age of sixteen who they consider at risk to themselves, others, or from others.

1.2 That existing and other social service agencies to augment their facilities and programs to meet the special needs of youth between the ages of twelve and sixteen.

1.3 That consideration be given to the establishment of a self-regulating, body comprised of the social service network including the police to:

a) Coordinate programs

b) Enhance communication

c) Share information with the common objective of protecting youths at risk.

1.4 That parents be given the right to obtain information from the police, and social service agencies regarding the where abouts, health welfare, and safety of their children provided this does not put the youth at risk.

1.5 That youth under the age of sixteen be provided access to health services which target the health and addiction problems which put them at risk.

1.6 That education relating to the risks and potential consequences of street life be promoted through a variety of channels including:

a) The educational system

b) Provincial Government advertising

c) Social Service Agencies

d) Other interested organizations

(Attach additional pages if required / Joindre des feuilles supplémentaires au besoin)

Signature of Foreman / Signature du président du jury

M E Mutton

Signature of Coroner / Signature du coroner

Note: Section 31 of the Coroner's Act provides as follows:

(1) (1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,
a) who the deceased was;
b) how the deceased came to his death;
c) when the deceased came to his death;
d) where the deceased came to his death; and
e) by what means the deceased came to his death.
(2) The jury shall not make any finding of legal responsibility or express any conclusion of law on any matter referred to in subsection (1).
(3) Subject to subsection (2), the jury may make recommendations directed to the avoidance of death in similar circumstances or respecting any other matter arising out of the inquest.
(4) A finding that contravenes subsection (2) is improper and shall not be received.
(5) Where a jury fails to deliver a proper finding, it shall be discharged. R.S.O. 1980, c. 93, s. 31.

Remarque: L'article 31 de la Loi sur les coroners stipule que:

(1) (1) Si une enquête est tenue, les circonstances entourant le décès y sont examinées et les faits suivants y sont établis:
a) l'identité du défunt,
b) la cause du décès,
c) le moment du décès,
d) l'endroit du décès,
e) les circonstances entourant le décès.
(2) Le jury ne doit pas faire de déclaration de responsabilité civile ou criminelle légale ni énoncer de conclusion de droit sur les questions visées au paragraphe (1).
(3) Sous réserve du paragraphe (2), le jury peut faire des recommandations visant à empêcher qu'un décès se produise dans des circonstances semblables ou portant sur une question découlant de l'enquête.
(4) La conclusion qui contrevient au paragraphe (2) est inacceptable et irrecevable.
(5) Le jury qui ne parvient pas à une conclusion acceptable est libéré. L.R.O. 1980, chap. 93, art. 31.

CONSTUCTION SAFETY

2.1 (10) That the intent and relevant sections of the Occupational Health and Safety Act and Regulations for Construction Projects, be changed to include both the safety of workers and the general public.

2.2 (9) That it be mandatory for the Ministry of Labour to issue a "Hazard Alert" for all deaths occuring on a construction site, outlining the circumstances, contributing factors and preventative measures.

2.3 (8) That it be the responsibility of the general contractor and employees to ensure that the proper authorities are notified to remove any unauthorized persons from or in the vicinity of their construction site.

POLICE INVESTIGATION PROCEDURES

3.1 (12) That appropriate tests be conducted on all evidence discovered at the scene of a suspicious death that in some way might be linked to the potential cause of death.

3.2 (11) That the warrants of apprehension for both Kevin Minchin and Robert Deraiche be extended until police have had the opportunity to fully question them in this case.

NOTE: ALL RECOMMENDATIONS UNANIMOUS

THE CORONERS ACT - PROVINCE OF ONTARIO

VERDICT EXPLANATION - A

NAME OF DECEASED: Ms Patricia ("Trish") Carpenter aka Tamara Smoke

SHORT SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH:

On Friday, September 25th, 1992 workmen arrived on a construction site at 205 Yonge Street, and were startled and upset to find two feet sticking out from a small 2 ft x 2 ft. hole. Upon closer examination, they realized that this was a body and they called the police. Police, ambulance personnel, coroner, all arrived, and the deceased (still with identity unknown, and cause of death unknown) was removed and taken to the Coroner's Building. Although the identity was not established for some time, meticulous examination of the site was made by the police personnel, and statements were taken from all of the workmen on site.....and finally, statements from three of the four companions of the late girl, all on the morning of September 25th, 1992 It was not until 1400 hours that the Investigating Detective met with an Inspector from the Ministry of Labour, and other senior management of the site; the site, noting that protective hoarding had been placed over the hole where the girl had been found, and snow fencing had been erected and two gaps in the hoarding had been closed with hoarding. It was quite a change but the Ministry of Labour was not concerned because the deceased was not a workman, but a member of the public. This later was to become a matter of concern to the Coroner.

The background was that of street kids, or curb kids, in Toronto, and more specifically, of the place of the aboriginal kids in this social (?) fabric. In addition, consideration had to be given to the deep problem of the legislation enacted since the Bill of Rights....namely, the Child and Family Services Act which allows for no residential care of kids under the age of 16 years, excdpt under the Children's Aid Society, or the family, if the latter is able to cope. Nothing now can be done to get kids under the age of 16 years off the street unless they become felons or prostitutes. The Young Offenders Act, 1985 which replaced the old Juvenile Delinquency Act removed from the police their ability to approach a young person, obviously under age 16 years, and NEW to the street scene, to assist in getting that kid off the street before it would be too late. Since we have 3000 to 4000 new street kids arriving in Toronto every year, and that of these some 29% to 45% are all under the age of 16 years, there is a great problem in trying to bring to them shelter, warmth, food, health care, before they enter into crime.

Also, in 1988 the Native Child and Family Services was founded in Toronto, because it had been found that the Child Welfare System was not serving the needs of native children in Toronto, or in other cities, or on the Reserves.....Statistics show that 50% of native kids are adoptive breakdowns and are on our streets, or elsewhere, and the ARF calculates that 20% of the street kids in Toronto are aborignal/native. The underfunding for help for these native children has been quoted as being severe: out of $100,000,000 set aside for Child Welfare in Ontario, only $45,000 is allocated to native children issues. (This information was given by the Executive Director of the Native Child and Family Services, Toronto, and may be on the conservative side.)

The now deceased girl, Trish, although born in Toronto, was an aboriginal girl, who was known as a "runner", having run away from her broken home when she was only 12 years of age, and having been for some time in the care of the Catholic Children's Aid Society. No matter what the C.C.A.S. did for her, she always ran away from any help, and ended up on the streets, with her boy friend, R.D., who was more than eight years her senior, and streetwise. She had friends. She had a baby boy when she was only 14 years of age. She lived with him, sometimes she went home, and other times she bedded down in one of several hostels available to her, because many of the hostels never asked for I.D. nor for age, and when anyone did, she identified herself as Tamara Smoke, and over the age of 16 years.

She was NOT a prostitute. She and her friends made their money by panhandling, and then they would buy alcohol, glue, and often other drugs, and when those were gone, would return to panhandling. For some weeks prior to the birth of the baby, some hostels knew she was pregnant, and finally she obtained a Health Card and was able to get prenatal care and the baby was born in July at St.Michael's Hospital. She kept her baby.

THE CORONERS ACT - PROVINCE OF ONTARIO

VERDICT EXPLANATION - A

NAME OF DECEASED: Ms. Patricia ("Trish") Carpenter aka Tamara Smoke

SHORT SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH:

She had lived at her mother's home for a few weeks before the birth of the baby, and again for some weeks post partum------but then she wanted to leave home, with the baby, and manage on her own. She went to Jessie's where she and the baby were welcome, and she was able to get back to some schooling. Her real desire was to get off the street, and to this end, now that some of the Agencies were communicating with each other, success had been achieved on September 24th: she and the baby were to be accepted into Massey House even though she was under the age of 16 years. This centre is attached to the C.C.A. Society and is a 6 month programme, plus another 6 months, with some hope of extension. But Trish never became aware that she had been accepted, as she died that night or early the morning of September 25th.

On September 24th, in the afternoon, Trish and R.D., K.M., B.K., and Vee got together for a "party". They drank two bottles of wine in the afternoon, and then with their accumulated wealth from panhandling, they bought a 60 oz bottle of rye, some coca cola, some glue, and went in behind the hoardings at 205 Yonge Street around 1730 hours to party. Some workmen saw them, waved, but did not tell them to leave. Later in the night, Trish passed out and two of the men were unable to get her up off the ground and decided to leave her there. They and Vee certainly intended to return for her. The companions seemedto drift off.....one, K.M. after fighting with two of the men, simply jumped over the hoardings and was gone. R.D. was taken to St. Michael's Hospital for a laceration and later, we believe, ended up at Seaton House. The other two were traced to a bank machine where they slept for the rest of the night.

When the body was discovered in the hole excavated for an outdoor stair, (excavated in mid-July) R.D. came onto the site obviously looking for Trish, although he had not named her. He was taken in for questioning and with his help, Vee and R.K. (the latter two were credible witnesses at the inquest) were identified panhandling at the World's Largest Bookstore, and were also taken in for questioning. The Homicide Squad was involved in the investigation, reviewed the site, and the photos taken by Headquarters Identification Bureau, and all that was found on site was finger-printed, or at least, attempts were made to finger print all of the evidence. This proved to be an impossible task as prints could not always be lifted.

The autopsy was carried out the following morning with due haste and an act, or acts, of violence ruled out by the pathologist. He stated that she had died of asphyxiation, due to being in the inverted position in the narrow hole, with a blood alcohol level of 288 mgm %, a near lethal level.

There were many theories as to how she got into that hole. All labourers, workmen, and those associated with the site, declared that it was impossible for her to have stumbled and fallen into the hole; others could find no evidence of homicide, the others being veterans in the Homicide squad. There was an impasse, that was settled by the fact that the mother of the deceased simply had to have all of the information brought forward at an inquest, and, it was evident that there were so many issues involving street kids in general, that an inquest could prove to be extremely useful if recommendati could be brought forward to the attention of the Government.

The inquest, therefore, was set for February, 1st, 1993, and the Verdict and Recommendatio were unanimous. The Jury heard from 34 witnesses. More could have been sought for even more opinions, but they were given the highlights of what is being done, and what can done under current legislation, for these kids under the age of 16 years. It is hoped also that the special needs of the aboriginal/native kids will be further examined after these findings are presented to the Chief Coroner's Office.

M E Milton

Margaret E. Milton, M.D. Coroner
Feb. 16-19th, 1993

THE CORONERS ACT - PROVINCE OF ONTARIO

VERDICT EXPLANATION - B

NAME OF DECEASED: Ms. Patricia ("Trish") Carpenter aka Tamara Smoke

REASON FOR EACH RECOMMENDATION WITH BRIEF EXPLANATION:

SOCIAL SERVICES

1.1. That theChild and Family Services Act, Section 37, be amended to provide police with authority to apprehend youth under the age of sixteen who they consider at risk to themselves, others, or from others.

Explanation: Detective David PERRY, of the Juvenile Task Force, gave evidence that since the enactment of the Young Offenders Act, police have been unable to get children under the age of sixteen, off the street because they have lost the authority to arrest as they had under the Juvenile Delinqunecy Act, unless the child has become a felon or a prostitute.

1.2. That existing and other social service agencies to augment their facilities and programmes to meet the special needs of youth between the ages of twelve and sixteen,

Explanation: The fact is that there are now thousands of kids under the age of sixteen, on the streets near Yonge Street core, and that that number will again be greatly increased come the spring. Statistics were given that there are between 3000 and 4000 new run-aways on Toronto streets every year, and that the majority of the new kids are all under the age of sixteen, For them to be admitted to one of the many hostels that have sprung up from necessity, they cannot be admitted if under age sixteen years, and so they lie about their age and identity. The Jury felt that forcing a child to lie in order to find shelter, when in need, should be addressed in Legislation, since if "caught", these children by law would have to be turned over to theChildren's Aid Society.

1.3 That consideration be given to the establishment of a self-regulating body comprised of the social service network including the police to:

a) Coordinate programs
b) Enhance communication
c) Share information, with the common objective of protecting youth at risk.

Explanation: It appeared in evidence that Trish had learned how to use the many facilities availableto youth aged 16 years and over, and that she could get whatever she wanted by using a fake name, fake I.D., and she knew that no one hostel would communicate with the other because of "confidentiality" and the accepted wisdom of these workers that they had to gain the "trust of their clients" and so would not try to find out where else they may have been seeking help. This recommendation is self-explanatory. Only Covenant House had a good sized file on Trish, and knew about the other agencies where she had received help, until the third week of September, 1992, when somehow they got together (some of them) and organized to get her accepted to Massey House.

1.4 That parents be given the right to obtain information from the police, and social service agencies regarding the where abouts, health, welfare and safety of their children, provided this does not put the youth at risk.

Explanation: In Trish's case, her mother sought her out through the police, as well as through the Courts, and was heart-breakingly unsuccessful, coming up continually against the brick-wall of "confidentiality"....the child comes first. It was shown in evidence that the vast majority of the children have run away from abusive situations, but for the parent(s) who sincerely are looking for a child, to have the police and social agencies put the privacy of the child on the street, higher than the concern of a parent, seemed to this Jury, and to many of the witnesses, hard to believe. They felt that parents have every right to be assisted in finding that child----and it would be understood that if the child had run from an abusive situation, the child would be protected.

M. E. Milton

THE CORONERS ACT - PROVINCE OF ONTARIO

VERDICT EXPLANATION - B

NAME OF DECEASED: Ms. Patricia ("Trish") Carpenter aka Tamara SMOKE

REASON FOR EACH RECOMMENDATION WITH BRIEF EXPLANATION:

1.5 That youth under the age of sixteen be provided access to health cervices which target the health and addiction problems which put them at risk.

Explanation: This recommendation is self-explanatory. Because a child under the age of sixteen must lie in order to get a Health Card, thatchild may never get health care. In the case of Trish, she became pregnant, and finally was able to get pre-natal care and was admitted to hospital for delivery of the child. She also was able to have assistance from Public Health Nurses, etc.

But the bigger picture is that of the addictions that are rampant amongst street- and curb-kids. Although the Addiction Research Foundation has spread out to assist these children, the hostels currently operating for young adults do not have associated with them any health care workers (i.e. doctors), and the lack of a Health Card was seen as a hindrance in the care of these kids who get spaced out on alcohol, drugs, anything, to ease the pain of being onthe streets..

1.6 That education relating to the risks and potential consequences of street life be promoted through a variety of channels including:

(a) The educational system
(b) Provincial Government advertising
(c) Social Service Agencies
(d) Other interested organizations.

Explanation: The Juvenile Task Force already is taking programmes into the high schools and wherever they are asked to speak. However, it was apparent that reaching high school students is too late in life: that education re the dangers of street life in Toronto, in particular, should be brought to the attention of kids in Grades 6, 7 and 8....i.e. in elementary school.

The actual films and material in the library of the Metro Police Force could be used to great advantage, but used according to the age and sophistication of the audience. For example, the more expressive and detailed tapes could be used for Home and School Meetings, and also for various service clubs, such as the Kiwanians and Rotarians, and various Church organizations.

It is hoped that the Provincial Goverment may develop warning spots on TV, in prime time, aimed at young listeners (such as the later spots devoted to worker safety), with the actors and actresses being drawn from their own age-group. Whatever is to be done, the Jury saw that it is urgent that education be at the forefront because "today's youth will be tomorrow's adults" and we will be losing a whole generation....soon.

CONSTRUCTION SAFETY

2.1 That the intent and relevant sections of the Occupational Health and Safety Act and Regulations for Construction Projects, be changed to include both the safety of workers and the general public.

Explanation: This is obvious. But, to go back to the scene where Trish was found dead, upside down in an excavation that was only 2 x 2 ft (but 6 feet deep), having fallen there, or been placed there, during the hours of darkness, while intoxicated, it is obvious that that hole ought to have been left covered by a plank or plywood or been surrounded by some type of hoarding. None of the workers on site were overly concerned about this hole.....and none of them thought that anyone could fall into it. They, as workmen, were completely oblivious to the danger. The fact was that ONE girl had ended up in that hole, and died. She had not died prior to being found upended.

Hoardings are there to protect the site and the workmen.....but the Jury felt that even though street kids could jump over hoardings, nonetheless, a site ought to be completely enclosed, and more thought must be given to the safety of the public. It was pointed out that there are thousands of street

THE CORONERS ACT - PROVINCE OF ONTARIO

VERDICT EXPLANATION - B

NAME OF DECEASED: Ms. Patricia ("Trish") Carpenter aka Tamara Smoke

REASON FOR EACH RECOMMENDATION WITH BRIEF EXPLANATION:

kids who are attracted not only to stairwells, to roof-tops, to parks, but also to construction sites because they so often provide for them privacy from the police and other kids (or gangs), andalso, in the cold, provide them with some weather protection, and if lucky, even with tarpaulins. When drunk or inebriated on other drugs, they would, in the dark, have a greater propensity to fall or injure themselves on the sites which otherwise might seem safe to workmen.

2.2. That it be mandatory for the Ministry of Labour to issue a "Hazard Alert" for all deaths occurring on a construction site, outlining thecircumstances, contributing factors and preventative measures.

Explanation: The treatment of the site where Trish had died by the Inspector from the Ministry of Labour was criticized. The Inspector had issued an order on September 25th, 1992, after meeting with the Investigating Officer, and with the owner of the site, and the General Contractor of the site, and took pictures, etc. However, he arrived at 1400 hours, and between the hours of 1130 and 1400 hours, hoardings had been erected (one bisecting the hole where Trish's body had been found), snow fencing was up, railings up, etc. The Inspector had been told by the Investigating Officer that the entire area where Trish's body had been found had been altered. But, the inspector wrote up his report with no mention of the girl's body having been found on site, nor any details as to what had preceded her death. In fact, he had taken no statements from any of the workers until January 10th or 12th, 1993, even though he had been informed that an inquest would be held on February 1st, so informed on October 12th, 1992.

Because he had been advised that the Occupational Health and Safety Act covered only the workers and not someone found dead in a hole/excavation on the site, the Inspector acted as though the death of Trish had not even occurred. This recommendatinn was made so that Construction Companies/ General Contractors and the Ministry of Labour, would strive to warn all other companies that suspicious deaths, accidental deaths, etc., can happen on their sites if their sites are not left secured and with all holes covered after work hours.

2.3 That it be the responsibility of the general contractor and employees to ensure that the proper authorities are notified to remove any unauthorized persons from or in the vicinity of their construction site.

Explanation: The Jury was very concerned about the fact that none of the workers nor the foreman, nor any of the sub-trades who saw the five inebriated persons on site, tried to ask them to leave (because they did not want to cause any trouble to themselves) but still were loathe to call the police. They indicated that when they DID call the police, the latter were slow to respond. However, in this case, none of them called the police to remove the five people from the site, and the Jury stated that in all cases, the police must be called....

POLICE INVESTIGATION PROCEDURES

3.1 That appropriate tests be conducted on all evidence discovered at the scene of a suspicious death that in some way might be linked to the potential cause of death.

Explanation: This must refer to the fact that toluene was not amongst the substances tested in the blood of Trish. However, it had not been ordered by the coroner because at the time the autopsy was ordered, there was no evidence that Trish herself had been glue-sniffing along with the men. (That came out during the inquest.) Also, the police DID attempt to get finger-prints off all bottles, all surfaces, all glue tubes, etc., but that finger-prints simply could not be lifted. In future inquests, it is apparent that more time must be spent with the Jury while the evidence is being given, to inform them about the actual manner in which these tests are done. To my recollection, I cannot remember anything that was not tested exhaustively by the police identification unit.

M S Milton

THE CORONERS ACT - PROVINCE OF ONTARIO

VERDICT EXPLANATION - B

NAME OF DECEASED: Ms. Patricia ("Trish") Carpenter aka Tamara SMOKE

REASON FOR EACH RECOMMENDATION WITH BRIEF EXPLANATION:

3.2 That the warrants of apprehension for both K.M. and R.D. be extended until police have had the opportunity to fully question them in this case.

Explanation: The Jury was unable to understand that these two witnesses simply could not be found, although warrants for them to attend at the inquest had been issued. The explanations were given to them with respect to R.D. R.D. was the father of the child, but also had a lengthy criminal record (given to the Jury). He was on probation until the end of November, 1993, and so obviously had not wanted to be found at the time of the inquest. However, there was evidence that he had maltreated Trish on occasions, and had given her a "black eye" and certainly had left her unconscious on the ground on September 24th....and had come back on the 25th quite agitated, asking "is she all right?"

But, the police HAD taken a full statement from him that morning. The Homicide Squad had taken a lead role in taking the statements from three of the four who had been with Trish the previous night, including R.D. All statements resulted in no charges being laid, and further investigations indicated that a homicide had not taken place. R.D. had fully co-operated, but obviously, the Jury had wanted to see him on the stand, and to listen to any cross-examination. He absented himself, but the police will always remember and will eventually pick him up for re-examination and will report back to the Coroner should anything relevant be uncovered.

In the case of K.M., he simply disappeard over the hoarding fence the night of September 24th, after fighting with R.D. and another man (who was a witness at the inquest), and was last heard of as going to see a sick relative in Kenora, and also being in Winnipeg. There was only one sighting of him in October or November, and then no word since that time. There was no way that a Warrant could be served, and it is unlikely that he would have heard about the inquest if he were not in Toronto.

The police sought diligently in all of their haunts for the few weeks just prior to the Inquest, and also every night during the Inquest, and these two witnesses simply could not be found, despite the large network used by the police.

Assurances had been given to the Jury by the Investigating officer that the case would be kept open with respect to these two men, whose pictures were entered in as exhibits, and it is my belief that the Jury made this recommendation as an assurance to the mother and her extended family, that Trish's death would not be forgotten with the end of the Inquest.

Coroner's Note: The Investigating Officer and his partner were most diligent in obtaining statements from all witnesses at the work site on the day that Trish was found...,and later in bringing all except for one, to the Inquest. They also included the owner of the site, the president of the General Contracting Company, etc. Other witnesses at the inquest included numerous social workers and hostel workers from Jessie's, from Turning Point, Covenant House, and the Native Child and Family Resource Centre (all non-mandated agencies) and from the Catholic Childrens Aid Society and from the Metro Children Aid Society. The evidence of these workers, and from Detective PERRY of the Juvenile Task Force, could well form a paper for all Ontario Coroners to share with schools in their own areas, to deter children from being drawn to the "mean streets of Toronto".

M S Mullin

February 16-17th, 1992