Hearing - 2001/File - D2001-47

INQUEST INTO THE DEATH OF

WILLIAM EDGAR

VERDICT OF THE JURY

OFFICE OF THE CHIEF CORONER

MINISTRY OF THE SOLICITOR GENERAL

June 19, 2001 to September 6, 2001

Office of the Chief Coroner

VERDICT OF CORONER'S JURY

We

	of	Peterborough, Ontario
	of	Peterborough, Ontario
	of	Peterborough, Ontario
	of	Peterborough, Ontario
	of	

Surname: EDGAR William

aged: 13 held at: Peterborough County Courthouse, 400 Water St. Peterborough, Ontario

on the 19th (Nineteenth) day(s) of June 2001
thru September 6, 2001

by: Dr. Peter A. Clark, Coroner for Ontario

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

1. Name of deceased: WILLIAM EDGAR
2. Date and time of death: March 31, 1999 – 14:57 hours
3. Place of death: Chedoke McMaster Hospital – Hamilton, Ontario
4. Cause of death: Hypoxic Encephalopathy and Bronchopheumonia Due to Asphyxia While Being Restrained
5. By What means: Homicide

(Continue on page 2 if necessary)

This Verdict was received by me this 6th day of September 2001

Signature of Coroner

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RECOMMENDATIONS

LEGISLATION / REGULATIONS

1. The Ministry of Community and Social Services must establish standards and regulations relative to the safe usage of restraints upon children and youth which specifically deal with the mechanics of any application of a restraint, and narrowly limit the usage of any restraint ***only*** to situations where there is a clear and immediate risk of serious physical injury.

2. The Ministry of Community and Social Services, should ensure that all group home ***manuals*** contain Ministry sanctioned standards of safe restraint procedures, setting out in clear and precise language when a restraint procedure is permitted and how it is to be applied (with illustrations) and monitored and post-restraint procedures that must be followed.

3. The Ministry of Community and Social Services should ensure that the program manual for each group home contains a debriefing procedure to be followed. This debriefing should be geared to the psychological and emotional needs of the restrained child.

4. Any use of restraint on a child in accordance with safe restraining techniques should be administered by two or more staff persons who have certified training in the proper and safe use of restraints acceptable to and approved by the Ministry.

   - The usage of restraints should only occur ***after*** less restrictive interventions have been determined to be ineffective.

   - The use of restraints on children and youth should be considered ***a last resort*** in situations of imminent risk or harm to self or others. The terms "imminent risk" and "harm" need to be clearly defined to address issues of safety only.

5. The Ministry of Community and Social Services, should monitor compliance with its policies regarding the use of behaviour management approaches including restraints, the Best Practice Guidelines and training requirements for staff employed in children's residences through the process of Licensing and annual Licensing reviews. This will require that the Licensing Regulations be revised.

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6. The Ministry of Community and Social Services should immediately commence a review of the ***Child and Family Services Act*** with a view to updating ***Part VI – Extraordinary Measures*** to provide a clear definition of intrusive procedures and to establish clear legislated limits on their use on children and youth in the care of service providers under the child welfare and children's mental health systems.

7. The ***Child and Family Services Act*** should be amended to establish a Review Panel to monitor the use of intrusive measures on children and youth in care and advise the Ministry on best practices and policy.

8. The licensing regulations pursuant to the ***Child and Family Services Act*** should be amended to ensure compliance by the licensee with the Act and its intent, including the following.

   - Use of restraint should clearly be differentiated in the service provider's policies from disciplinary practices.
   - Licensing review should include a review of all incident reports of the use of restraints to ensure compliance with the legislation.
   - Terms such as ***time out***, ***isolation***, ***restraint*** and ***removal*** should be clearly defined in the regulations and licensing guidelines and be incorporated in the policies of the licensees.

9. The licensing regulations pursuant to the ***Child and Family Services Act*** should be amended to establish clear criteria by which to monitor the quality of services provided to children and youth in the care of licensed service providers including the following:

   - Criteria by which to evaluate the behaviour management plan of the facility or residence to ensure it is in the best interests of the children and youth.
   - Specific criteria to be included in the plan of care for each child or youth in the residence to ensure an individualized behaviour management plan.
   - Specified ongoing training of staff that is formalized and external in addition to ongoing internal training and clinical support.

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10. ***The Child and Family Services Act*** should be amended to require that children and youth in care have the right to be informed of the extraordinary measures or intrusive procedures used by the service provider upon admission to the residential placement.

11. Although the Act clearly states that children in care are not to be subjected to corporal punishment, the legislation should be amended to more clearly define the term to provide greater accountability and certainty by excluding the use of physical force on a child as a consequence or punishment for behaviour other than to prevent imminent harm to self or to others.

RESEARCH, COMMUNICATION, DISSEMINATION

12. The Ministry of Community and Social Services should establish and maintain ***direct communication linkages*** to every service provider in the province for the purposes of the dissemination of information dealing with issues of concern or best practice and ongoing reviews of both ***Special Incident Reports*** and ***Serious Occurrence Reports*** on a regular basis.

13. The Ministry of Community and Social Services should establish a ***database*** for the collection and compiling of all Serious Occurrence Reports, including those detailing the application of force by way of restraint upon a child. Such documentation should be available for research purposes both internal and external to the Ministry.

14. Ministry of Community and Social Services should conduct research to identify behaviour management models that ***do not*** rely on the use of physical restraint ***but stress*** prevention, early intervention approaches, strategies and techniques.

15. Ongoing medical research should be conducted on the effects of psychotropic medication, specifically related to children, with particular emphasis on any risks to their health and well being, and contraindications to the use of medication or combination of medications.

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16. A single mechanism for collecting the findings and recommendations of a systemic nature from the ***reviews of individual child deaths*** should be created, with the capacity to analyze the findings and make recommendations that might prevent similar deaths across the province. This process must ensure timely dissemination of information to agencies and professional groups directly involved in providing service in similar circumstances. Such a mechanism would not preclude agencies or Ministries of government from having separate processes to address internal accountability issues, but would be a vehicle for identifying trends and systemic issues and ensuring that these are broadly publicized.

17. The Ministry of Community and Social Services ***shall alert*** all Service Providers when a death of a child in care occurs and the circumstances thereof.

ENHANCING THE VOICES OF CHILDREN AND YOUTH

18. Ministry of Community and Social Services should ensure that residential placements for children and youth respect the right of children to participate in decisions that affect them including decisions about the programs, routines, rules and consequences within the residence to the extent that the children are capable.

19. The Ministry of Community and Social Services should adopt a province-wide policy guaranteeing access to group homes and the residents to their rights education through the Office of the Child and Family Services Advocate.

20. Ministry of Community and Social Services should issue a province-wide policy prescribing a rights education program for group home operators which identifies all avenues of recourse that are available to a child in care if they feel mistreated, unsatisfied with their placement or caregiver, or desire clarity about their rights.

21. As recommended in ***Voices from Within: Youth Speak Out***, all youth in care must have an independent voice and the opportunity for peer support across service sectors. Ministries involved in the care of children must collaborate to ensure that this voice is heard. Peer advocacy programs should be provincially funded.

22. The Ministries involved in the care of children and youth should continue their support and implementation of the recommendations contained in ***Voices From Within: Youth speak out***.

23. Children in the care of a group home must be given accessible and effective opportunities to express any personal concerns relative to the safety of their environment and the manner in which they are treated.

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24. Childrens Aid Society and Ministry personnel charged with supervising the placement of children in group homes, of licensing and of assessing the conditions that exist in group homes, must take specific measures which ensure that meaningful, and appropriate opportunities are regularly available for children in care to articulate and identify personal concerns they may have relative to their safety and to the care being given.

BEHAVIOUR MANAGEMENT INTERVENTIONS

25. Best Practice Guidelines regarding the use of behaviour management interventions in children's residences should be developed by the Ministry of Community and Social Services for province wide application.

- Such guidelines should de-emphasize the use of restraints, focusing more on prevention, non-intrusive intervention and de-escalation techniques.

- Youth consultation should be a requirement of any contract or strategy to develop best practices and policies and training models for behavioural management interventions.

26. The Ministry of Community and Social Services, together with the Ministries of Health and Corrections and other appropriate Ministries, should work collaboratively to implement the recommendations from the Interministerial/Intersectoral Steering Committee on Behaviour Management Interventions for Children/Youth in Residential and Hospital Settings.

27. The use of intrusive measures should take into consideration the individual child's history and medical status and any contraindications to the use of restraint. These considerations should form part of the Child's Plan of Care.

28. The Ministry of Community and Social Services should adequately fund the development of a training curriculum for behavioural management intervention which emphasizes the best practices principles articulated by the Steering Committee on Behaviour Management Interventions for Children and Youth in Residential and Hospital Settings.

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ENSURING QUALITY OF CARE

29. Any physician and consulting psychiatrist (if there is one) involved in the care of a child resident in a group home or other such facility should receive the full social and medical history of the child, and should be specifically consulted and have input into the formulation of the child's initial Plan of Care and receive copies of all subsequent Plans of Care on a timely basis.

30. An initial Plan of Care (i.e. created upon admission to a group home or other facility) should specifically address any recommendations made by any discharging facility relative to the child's subsequent care. Specific reasons should be given for any departure from such recommendations. Copies of Plans of Care, along with copies of documentation verifying the completion of any contemplated health initiatives, should be supplied by the service provider to the long term care Childrens Aid Society worker having responsibility for the child in care.

31. ***Long Term Care workers*** should maintain, in the file of each child in care, a medical history, Special Incident Reports, Serious Occurrence Reports and Plans of Care, a check list of those medical and other initiatives to be undertaken in periods between Plans of Care together with documentation verifying the completion of such initiatives.

32. *Long Term Care workers* should specifically review in Plans of Care any plans of action for behavioural management interventions and express agreement or disagreement with such plans or any modifications made to them.

33. *Licensees* compliance with provincial standards must be monitored through unscheduled visits by licensing officers and/or program supervisors from MCSS at different times of the day and week, including evenings and weekends.

34. The prescribing physician should monitor children and youth that are placed on psychotropic drugs or a combination of drugs at frequent intervals. Where the prescribing physician delegates monitoring to another physician, there must be a timely, direct and complete exchange of information between the physicians.

35. To ensure real accountability and provide a high standard of care for children, provincial standards for residential care must be enforceable.

36. MCSS should ensure that child welfare agencies have a clear mandate and protocol to investigate child protection issues, including physical abuse and neglect, within institutions and residential service providers.

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TRAINING

37. The Ministry of Community and Social Services should make it a **mandatory** requirement that every person performing a **direct care** function in group homes and other facilities in the child care sector possess current certification in an accredited programme of ***First Aid*** and ***Cardiopulmonary Resuscitation (CPR).***

38. Following the recommendations of the Intersectoral Interministerial Steering Committee, the Ministry of Community and Social Services should lead in the development of a ***standardized external training*** programme for the behavioural management of children and youth in care.

39. A standardized training curriculum, which incorporates a full range of behaviour management approaches and techniques, should be developed and implemented across the province, along with requisite annual refresher training. The standardized training curriculum should reflect and incorporate the Best Practice Guidelines.

40. The Ministry of Community and Social Services should require that ***staff employed in children's residences*** are trained in the standard curriculum and behaviour management and receive the requisite refreshers.

41. *Child protection staff* should receive training on the behaviour management interventions used with children in residential care pursuant to the Best Practices Guidelines, in order to enable them to interpret the Special Incident Reports received from resource providers.

42. Staff responsible for the care of children in residential placements should have a requisite standard level of education or training ***prior to*** caring for and treating children and youth. This training should include relevant college and/or university human services training programs or the equivalent, in addition to mandatory training in First Aid and cardiopulmonary resuscitation (CPR) specific to children.

43. ***Residential care providers*** must ensure staff are knowledgeable in sound clinical interventions for vulnerable youth. Staff should be required to maintain and demonstrate a minimum level of continuing education to address the complex needs of the children and youth in their care.

44. The Ministry of Community and Social Services should ensure adequate funding to licensees for the purpose of staff training and hold them accountable for the expenditure of funds for ongoing formalized training of staff

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45. Licensing officers and program supervisors with the Ministry of Community and Social Services, and long term workers/child protection workers of Children's Aid Societies, should have a basic level of training in respect of behaviour management interventions, First Aid and CPR, in order to adequately evaluate the programs and standard of care provided by licensed residential service providers.

PHYSICAL RESTRAINTS

46. The Ministry of Community and Social Services should prohibit the ***face-down-arms crossed over chest restraint position***. Such a position is dangerous, life threatening and poses extreme risk of causing asphyxiation.

47. There should be clearer direction on how restraints should be applied. An ***Illustration booklet*** showing the proper step by step restraint procedure should be incorporated in all the residential care program manuals specifically stating:

- How restraints are to be used
- How a child is moved from a sitting position to the floor restraint
- Who should be doing the restraint
- How many people should be involved in the restraint process
- How to hold the child comfortably and safely
- Monitoring the child

48. During any restraint the child's condition must be continually assessed, monitored and re-evaluated and the restriction of the child's movements or activity by restraint must be ended at the earliest possible time, considering the child's safety while being restrained.

49. ***At all times***, two people should be involved during the application of a physical restraint, to ensure the child's condition is monitored and to apply the correct restraint in a safe and controlled manner.

50. The caregiver most familiar with the child's behavioural habits and who has the strongest relationship with the child should attempt to intervene and de-escalate a situation prior to a physical restraint.

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MONITORING / REPORTING REQUIREMENTS

51. The Ministry of Community and Social Services should require a standardized format for ***Special Incident Reports*** be utilized by all service providers. This standardized reporting ***format*** for Special Incidents should include information about:

- the reasons for / causes of the incident
- the specific de-escalation attempts which were made and the effects of these
- a detailed description of any application of force to a child (including removals and restraints); the mechanics of the application of force, the length of any restraint and the results of the application of force to be clearly identified
- a history of any conversation between the child and persons involved in, or monitoring, the application of force
- a complete record of any complaints made by the child prior to, during, or immediately following the application of force
- a record of the specific steps taken to monitor the child during the application of force, including the tracking of pulse and respiration rates, skin colour and ability to engage in conversation
- a detailed description of any change in the physical appearance or level of mental alertness / consciousness of the child AND the actions taken by staff to address such changes
- any injury however minor to the child
- a notation that the service provider's medical practitioner has been informed concerning this application of force in a timely manner
- a outline of the debriefing that subsequently took place (a) between supervisory staff and those members of staff involved with the application of force and its monitoring (b) between staff personnel and the child
- an indication of any changes that are contemplated to the child's behavioural management program
- an inclusion should be the attachment of the child's version of the event

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MONITORING / REPORTING REQUIREMENTS

52. The Ministry of Community and Social Services should require that all incidents involving the application of force to a child by way of restraint be deemed to constitute an ***'Occurrence'*** for which a ***Serious Occurrence Report*** must be filed by the service provider.

- A copy of the full report is to be submitted to the Ministry of Community and Social Services Regional Office that exercises ministry licensing and supervisory responsibility over the service provider.
- A copy of the original full report is to be sent to a central repository of the Ministry.
- The Serious Occurrence reporting requirements should make it clear that ANY injury, however minor, that occurs in the course of a restraint must be reported as a Serious Occurrence.

53. The Ministry of Community and Social Services should require a ***standardized format*** for the reporting of Serious Occurrences as defined in legislation. With respect to the application of a restraint, the format should be similar to that of the standardized Special Incident Report.

54. The Ministry of Community and Social Services should require a ***standardized format*** for a ***Plan of Care*** to be utilized by all service providers. This standardized Plan of Care format should include information about:

- behavioural management / intervention plans of action to be followed
- description of those intervention approaches which were most effective in avoiding the application of force
- any contemplated modifications to intervention plans of action
- specific subsections under the general heading of health indicating actions previously contemplated (medical checkups, blood tests, medication reviews, etc.) and the completion and overall results of such

55. Long Term Care workers and Children's Aid Societies should receive full copies of all ***Special Incident Reports*** and ***Serious Occurrence Reports*** generated by the service provider respecting children placed in care by their particular society. Copies of such reports should be received within one business day of the event having taken place.

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MONITORING / REPORTING REQUIREMENTS

56. The Ministry of Community and Social Services should require that each service provider maintain *roll ups* of all usages of restraints described in the comprehensive and standardized Special Incident Reports. These summaries should be made available and be reviewed on a regular basis by Ministry licensing and program supervision personnel. The information provided through the annual roll-up and individual incident reporting would be considered in assessing compliance with policies and best practice guidelines with respect to behaviour management interventions and other licensing requirements.

57. The service provider shall forward to the Consulting Psychiatrist and Family Physician a copy of all *Special Incident Reports* where a restraint is used clearly indicating:

- Description of the restraint used
- The physical effects if any on the child

58.. The Ministry of Community and Social Services should more closely monitor serious occurrence reports and ensure that all ***placing agencies*** in the province have access to information in respect of the frequency of serious occurrences in residential placements.

OTHER

59. The Ministry of Community and Social Services should take steps to create greater ***pay equity*** across the Child Care Sector to ensure that children and youth in group homes and other facilities have equal access to high quality care.

60. The Ministry of Community and Social Services should undertake a fundamental review of the needs of group homes and residential settings with a view to ensuring that ***adequate resources*** are available to provide a high quality of care, support and treatment.

Request the Chief Coroner of Ontario, Dr. James Young, formally consider our recommendations and report back to the Jury on what actions were implemented from the recommendations of the Coroners Inquest into the death of William Edgar on March 1999, and for the protection of children and youth.

Signature of Coroner

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December 3, 2001

Dr. J. G. Young
Chief Coroner of Ontario
26 Grenville Street
Toronto, Ontario
M7A 2G9

Dear Dr. Young

re: William Edgar Inquest
Verdict Explanation

The Inquest into the circumstances surrounding the death of 13 year old William Edgar was held at the Peterborough County Court House, 470 Water Street from June 19, 2001 to September 6, 2001. Counsel to the Coroner was Peterborough County Crown Attorney Mr. Brian Gilkinson. The following parties were granted standing and were represented by legal counsel.

Justice for Children, Youth and the Law (Canadian Foundation for Children, Youth, and the Law)	- Ms. Cheryl Milne - Mr. Richard Macklin - Mr. Julian Roy
Ms. Judy Edgar	- Mr. Michael Waud - Mr. Scott McMichael - Mr. E. L. Ehlers
Metropolitan Toronto Children's Aid Society	- Ms. Jane Long - Ms. Kristina Reitmeier
Management and Staff of the Cavan Youth Services Group Home	- Mr. Brian Greenspan - Ms. Sharon Lavine

Physicians involved in the care of William Edgar - Ms. Ellen Sealey

The Court Reporter was Ms. Barbara Harren, 86 Morrow Street, Peterborough, Ontario K9J 1X5.

I would like to give a brief synopsis of the sequence of events leading up to the death to be followed by an explanation for each of the Inquest Jury's recommendations. I would like to stress that my comments are related to my recollection of the evidence and my understanding of why the Inquest Jury made each recommendation. The sole purpose of the synopsis is to assist the reader in understanding the recommendations and is in no way intended to be considered as evidence.

HISTORY

William Edgar was born on September 2, 1985. His family situation was an abusive one and included a serious psychiatric illness involving one of his parents.

William's situation first came to the attention of the York Region Children's Aid Society (YRCAS) in May 1987. Further contacts occurred in September 1987, November 1987, and October 1989.

YRCAS took the children into care until December 1990 when they were reunited with their parents. The YRCAS continued to monitor the family until they moved to Simcoe County in April 1992 where they voluntarily became involved with the local CAS.

On July 30, 1994, William entered the residential treatment section of the Kinark Child and Family Services when the family was residing in the Barrie area. A further move to Toronto precipitated William's release from that program. The family, however, still did not feel they could provide for William.

In September 1995, the Metropolitan Toronto Children's Aid Society (MTCAS) opened a file on William when William was admitted to their care. William was voluntarily placed in a specialized foster home under a Temporary Care Agreement for a 7 month duration. This agreement was extended until the end of June 1996. In the meantime, the family was referred back to the YRCAS when they moved to the Woodbridge area in January 1996.

On July 8, 1996 William was formally admitted to the care of the YRCAS but he remained in his current foster home until an appropriate long term placement could be arranged. Williams' parents were cooperative with the proposed care plan.

On July 24, 1996, William's father died suddenly of an apparent heart attack. William's behaviour deteriorated significantly as a result of the loss of his father resulting in his admission to the Youthdale Crisis Unit in August 1996. William had become increasingly out of control in his foster home and was threatening suicide.

Following a 2 week stay in the Crisis Unit, William was admitted to the George Hull Centre on August 30, 1996 for stabilization, assessment, and long term planning purposes. William remained at the Centre until June 24, 1997 when he was placed at the Keene Residence of the Cavan Youth Services (CYS) where he resided until the time of his death.

A review of William's behaviour indicated that his behavioural problems started very early in his life. Abnormal behaviours included assaults on his sister, thefts, lighting fires, mischief to property, and uncontrollable acts of rage. William advised his caregivers that he would hear voices and see people coming out of the walls.

While residing at the Keene Residence of the CYS, William's behaviour was closely monitored by staff with the assistance of a child psychiatrist who prescribed Thioridazine and Imipramine to control William's outbursts of impulsive, aggressive, and destructive behaviour. It was noted that William's behaviour improved in that the number of episodes where restraint was required to control William significantly decreased from what was required during previous placements.

On March 29, 1999, after having returned form school, William was preparing to go outside to play when he got into a verbal altercation with one of the staff members. This resulted in William being denied his outside privileges. William was directed to sit on a chair at a desk in the dining area of the residence to calm down.

While in the chair, William became verbally abusive to staff and then began to stomp his feet and pound on the desk. Staff warned William that he would be removed to the den if he didn't calm down. William's aggressive behaviour continued to escalate which resulted in him being taken to the den where he was sat on a chair in the middle of the room. While in the den, William's behaviour was monitored by a staff person from a position in the hallway. Over the next 2 hours, William's behaviour continued to escalate. He was verbally abusive and threatened staff members. He then began to stomp his feet and physically raise himself off the chair. Continued warnings to calm down were ineffective. Believing that William was in imminent danger to harm himself or others, the senior supervisor grasped William's upper arms from behind and placed William on the floor in the prone position with William's arms crossed in front of his chest. The supervisor positioned himself across William's waistline/buttocks area, holding William's wrists at the side of his chest. William continued to struggle and advised staff that he couldn't breathe. Eventually William calmed down and ceased to struggle. Several staff members came to the doorway to check and see if everything was alright.

Eventually, it was decided that William had calmed down. When William failed to respond to inquiries if he was ready to get up, staff members realized that William was not breathing. Artificial respiration was commenced and emergency assistance was summoned.

William was transported by ambulance to the emergency room of the Peterborough Regional Health Centre where the emergency room physician noted the presence of petechiae and a bluish discolouration above William's nipple line. The diagnosis of compression asphyxia was made. William remained deeply comatose. William was transferred to the Chedoke Site of the McMaster University Medical Centre where his medical condition continued to deteriorate. At 1457 hours on March 31, 1999, William was pronounced deceased.

RECOMMENDATIONS WITH COMMENTS

1. The Ministry of Community and Social Services must establish standards and regulations relative to the safe usage of restraints upon children and youth which specifically deal with the mechanics of any application of a restraint, and narrowly limit the usage of any restraint **only** to situations where there is clear and immediate risk of serious physical injury.

Comment:

The jury was advised that the usage of restraints on children in group homes was unregulated in the Province of Ontario thusly allowing group homes to apply any type of restraint. The jury was of the opinion that the Ministry should take a leadership role in establishing standards and regulations relative to the safe usage of restraint. In this particular case, group home workers believed that restraint should be used in three situations; to prevent serious injury to the child, to prevent serious injury to the group home worker, and to prevent physical damage to the residence. The jury wanted to emphasize that restraint should only be used to prevent serious physical injury to the child.

2. The Ministry of Community and Social Services, should ensure that all group home **manuals** contain Ministry sanctioned standards of safe restraint procedures, setting out in clear and precise language when a restraint procedure is permitted and how it is to be applied (with illustrations) and monitored and post-restraint procedures that must be followed.

Comment:

In this particular case, the group home's manual did not contain instructions on safe restraint procedures. The jury felt that all group home manuals should contain specific instructions on when and how a restraint should be used and monitored, and post-restraint procedures that should be followed.

3. The Ministry of Community and Social Services should ensure that the program manual for each group home contained a debriefing procedure to be followed. This debriefing should be geared to the psychological and emotional needs of the restrained child.

Comment:

In this particular case, the group home did utilize a post-restraint debriefing procedure for staff which was designed to allow staff to identify precipitating factors that led to the restraint. Given the psychological and emotional impact that restraint has on a child, the jury felt that it was important that the post-restraint briefing should include the views of the child that had been restrained.

4. Any use of restraint on a child in accordance with safe restraining techniques should be administered by two or more staff persons who have certified training in the proper and safe use of restraints acceptable to and approved by the Ministry.

The usage of restraints should only occur **after** less restrictive interventions have been determined to be ineffective.

The use of restraints on children and youth should be considered **a last resort** in situations of imminent risk or harm to self or others. The terms "imminent risk" and "harm" need to be clearly defined to address issues of safety only.

Comment:

In this particular case, the restraint was applied by one person who had no formal certified training on the safe application of restraint. The jury heard evidence to the effect that restraining holds on children can be better applied by two persons. In addition, the jury wanted to emphasize the importance of applying a restraint only after less restrictive interventions had been utilized and deemed to be ineffective. The jury also wanted to stress the importance of applying a restraint as a last resort to prevent imminent risk to the child or others.

5. The Ministry of Community and Social Services, should monitor compliance with its policies regarding the use of behaviour management approaches including restraints, the Best Practice Guidelines and training requirements for staff employed in children's residences through the process of Licensing and annual Licensing reviews. This will require that the Licensing Regulations be revised.

Comment:

The jury was advised that all group homes in the Province of Ontario undergo an annual inspection which did not review behaviour management techniques including the usage of restraint and the qualifications of staff in group homes. The jury was of the opinion that the Ministry was in the best position to establish "Best Practice Guidelines" for all group homes in the Province of Ontario, guidelines which should be adhered to, not only at the time of the granting of the initial license, but also at the time of the annual licensing reviews.

6. The Ministry of Community and Social Services should immediately commence a review of the **Child and Family Services Act** with a view to updating **Part VI – Extraordinary Measures** to provide a clear definition of intrusive procedures and to establish clear legislated limits on their use on children and youth in the care of service providers under the child welfare and children's mental health systems.

Comment:

The jury was advised that Part VI of **The Child and Family Services Act**, the section that deals with **Extraordinary Measures** had been part of **The Act** since the mid 1980's but had never been proclaimed into law. The jury felt that this section should be reviewed and proclaimed into law to provide a clear definition of intrusive procedures and to establish clear legislated limits on the use of intrusive procedures for children in the care of the province.

7. The Child and Family Services Act should be amended to establish a Review Panel to monitor the use of intrusive measures on children and youth in care and advise the Ministry on best practices and policy.

Comment:

The jury was advised that there was no mechanism to allow for the monitoring and review of the use of intrusive measures on children and youth in care in the Province of Ontario. The jury was of the opinion that the establishment of a process to monitor and review the use of intrusive measures would be of great value to the Ministry in establishing best practices and developing policies.

8. The licensing regulations pursuant to the **Child and Family Services Act** should be amended to ensure compliance by the licensee with the Act and its intent, including the following:

   Use of restraint should clearly be differentiated in the service provider's policies from disciplinary practices.

   Licensing review should include a review of all incident reports of the use of restraints to ensure compliance with legislation.

   Terms such as **time out**, **isolation**, **restraint** and **removal** should be clearly defined in the regulations and licensing guidelines and be incorporated in the policies of the licensees.

Comment:

The jury wanted to ensure that the licensing requirements of The Child and Family Services Act should be amended to ensure that the use of restraint should be clearly differentiated from the use of discipline and that the commonly used terms such as time out, isolation, restraint, and removal should be clearly defined as to their meaning. In addition, the jury wanted to emphasize the importance of having the Ministry's licensing review officer review all of the group home's incident reports as part of the annual re-licensing process. Inherent in this recommendation is the importance of ensuring that the Ministry licensing reviewer is fully trained, knowledgeable, and competent to understand and review the contents of the group home's incident reports.

9. The licensing regulations pursuant to the **Child and Family Services Act** should be amended to establish clear criteria by which to monitor the quality of services provided to children and youth in the care of licensed service providers including the following:

   Criteria by which to evaluate the behaviour management plan of the facility or residence to ensure it is in the best interests of the children and youth.

   Specific criteria to be included in the plan of care for each child or youth in the residence to ensure an individualized behaviour management plan.

   Specified ongoing training of staff that is formalized and external in addition to ongoing internal training and clinical support.

Comment:

The jury wanted to stress the importance of having Ministry licensing evaluators be competent to evaluate the behaviour management plan for the child, to ensure that the behaviour management plan was in the best interest of the child, and to ensure that group home staff were properly trained utilizing both external and internal training modules.

10. **The Child and Family Services Act** should be amended to require that children and youth in care have the right to be informed of the extraordinary measure or intrusive procedures used by the service provider upon admission to the residential placement.

Comment:

The jury wanted to stress the importance of informing children in care of the types of extraordinary measures and intrusive procedures utilized by the group home in which he/she was being placed.

11. Although the Act clearly states that children in care are not to be subjected to corporal punishment, the legislation should be amended to more clearly define the term to provide greater accountability and certainty by excluding the use of physical force on a child as a consequence or punishment for behaviour other than to prevent imminent harm to self or to others.

Comment:

The jury was advised that The Child and Family Services Act needed to be amended to allow for a more clearly defined definition or corporal punishment. Inherent in this recommendation is the need to identify the need to restrain a child solely for their own safety and not as a consequence or punishment for unacceptable behaviour.

12. The Ministry of Community and Social Services should establish and maintain **direct communication linkages** to every service provider in the province for the purpose of the dissemination of information dealing with issues of concern or best practice and ongoing of both **Special Incident Reports** and **Serious Occurrence Reports** on a regular basis.

Comment:

The jury was advised that the Ministry received a vast amount of clinical information in the Special Incident and Serious Occurrence Reports submitted by licensed group homes. Evidence presented at the Inquest revealed that this information was neither analyzed nor communicated to all the group homes in the province. The jury was of the opinion that the Ministry should disseminate this information to all group homes in the province for the purpose of alerting and educating group home operators to issues of common concern throughout the industry.

13. The Ministry of Communication and Social Services should establish a **database** for the collection and compiling of all Serious Occurrence Reports, including those detailing the application of force by way of restraint upon a child. Such documentation should be available for research purposes both internal and external to the Ministry.

Comment:

The jury was advised that the Ministry received a vast amount of clinical information contained in the Serious Occurrence Reports. The jury was of the opinion that this information should be analyzed and the results of the analysis should be made available to the researchers within and outside the Ministry.

14. Ministry of Community and Social Services should conduct research to identify behaviour management models that do not rely on the use of physical restraint but stress prevention, early intervention approaches, strategies and techniques.

Comment:

The jury wanted to stress the importance of identifying behaviour management models that stressed prevention, early intervention approaches, strategies and techniques to manage unacceptable behaviours.

15. Ongoing medical research should be conducted on the effects of psychotropic medication, specifically related to children, with particular emphasis on any risks to their health and well being, and contraindications to the use of medication or combination of medications.

Comment:

The jury heard considerable evidence on the potential adverse effects of psychotropic medications in children, specifically, prolongation of the QT interval on the electrocardiogram. The jury wanted to stress the importance of conducting further research on the effects of these medications on children.

16. A single mechanism for collecting the findings and recommendations of a systemic nature from the **reviews of individual child deaths** should be created, with the capacity to analyze the findings and make recommendations that might prevent similar deaths across the province. This process must ensure timely dissemination of information or agencies and professional groups directly involved in providing service in similar circumstances. Such a mechanism would not preclude agencies or Ministries of government from having separate processes to address internal accountability issues, but would be a vehicle for identifying trends and systemic issues and ensuring that these are broadly publicized.

Comment:

The jury was advised that there were a number of reviews conducted into the deaths of children in Ontario. Evidence presented to the jury suggested that the results of these reviews were not readily available in a timely fashion to group home operators throughout the province.

The jury wanted to emphasize the importance of disseminating this information to group home operators in the interest of ensuring safety for children within group homes in Ontario.

17. The Ministry of Communication and Social Services **shall alert** all Service Providers when a death of a child in care occurs and the circumstances thereof.

Comment:

The jury was advised that there had been a prior death of a child, a death that was attributable to the application of a restraint. The director of the CYS advised the jury that he was unable to obtain any information on the circumstances surrounding the prior death. The jury was of the opinion that group home operators should be advised of adverse incidents in a timely fashion for the purpose of ensuring that future similar incidents did not occur. The dissemination of this information could certainly be done in general terms and would not violate the provisions of The Freedom of Information and Protection of Privacy Act.

18. Ministry of Community of Social Services should ensure that residential placements for children and youth respect the right of children to participate in decisions that affect them including decisions about the programs, routines, rules and consequences within the residence to the extent that the children are capable.

Comment:

The jury was advised that children generally did not participate in the decision making about the programs, routines, rules, and consequences within the group home. The jury wanted to stress the importance of involving children in these decisions to the extent that they were capable.

19. The Ministry of Community and Social Services should adopt a province-wide policy guaranteeing access to group homes and the resident to their rights education through the Office of the Child and Family Services Advocate.

Comment:

The jury wanted to emphasize the importance of the work done by the Office of the Child and Family Services Advocate and specifically wanted to ensure and guarantee that this office had access to all group homes in the Province of Ontario.

20. Ministry of Community and Social Services should issue a province-wide policy prescribing a rights education program for group home operators which identifies all avenues of recourse that are available to a child in care if they feel mistreated, unsatisfied with their placement or caregiver, or desire clarity about their rights.

Comment:

The jury wanted to stress the importance of ensuring that all group home operators in Ontario were knowledgeable about the rights of children in their care.

21. As recommended in **Voices from Within: Youth Speak Out**, all youth in care must have an independent voice and the opportunity for peer support across service sectors, Ministries involved in the care of children must collaborate to ensure that this voice is heard. Peer advocacy programs should be provincially funded.

Comment:

The jury was impressed with the contents of the report entitled **Voices from Within: Youth Speak Out**. The jury agreed that children in group homes needed an independent voice to express their opinions. This would be best accomplished by ensuring that peer advocacy programs were provincially funded.

22. The Ministries involved in the care of children and youth should continue their support and implementation of the recommendations contained in **Voices From Within: Youth Speak Out.**

Comment:

The jury was impressed by the recommendations contained within the report entitled **Voices from Within: Youth Speak Out** and wanted to ensure that the Ministries involved in the care of children continue to support and implement these recommendations.

23. Children in the care of a group home must be given accessible and effective opportunities to express any personal concerns relative to the safety of their environment and the manner in which they are treated.

Comment:

Once again, the jury wanted to emphasize the importance of ensuring that children in group homes had the opportunity to effectively express their concerns relative to their safety in group homes.

24. Children's Aid Society and Ministry personnel charged with supervising the placement of children in group homes, of licensing and of assessing the conditions that exist in group homes, must take specific measures which ensure that meaningful, and appropriate opportunities are regularly available for children in care to articulate and identify personal concerns they may have relative to their safety and to the care being given.

Comment:

The jury wanted to emphasize the importance that workers involved in the supervision of children in group homes had in ensuring that children placed in group homes were able to identify safety and care concerns within the group home setting.

25. Best Practice Guidelines regarding the use of behaviour management interventions in children's residences should be developed by the Ministry of Community and Social Services for the province wide application.

Such guidelines should de-emphasize the use of restraints, focusing more on prevention, non-intrusive intervention and de-escalation techniques.

Youth consultation should be a requirement of any contract or strategy to develop best practices and polices and training models for behavioural management interventions.

Comment:

The jury wanted to emphasize the importance that the Ministry identify best practice guidelines for the group home industry. The importance of involving youth in this process, especially for the purpose of identifying preventative interventions, was a major concern of the jury.

26. The Ministry of Community and Social Services, together with the Ministries of Health and Corrections and other appropriate Ministries, should work Collaboratively to implement the recommendations from the Interministerial/Intersectorial Steering Committee on Behaviour Management Interventions for Children/Youth in Residental and Hospital Settings.

Comment:

The jury was impressed with the recommendations developed by the Interministerial/Intersectoral Steering Committee on Behavioural Management Interventions for Children/Youth in Residential and Hospital Settings and felt that all the involved ministries should work together to implement these recommendations.

27. The use of intrusive measures should take into consideration the individual child's history and medical status and any contraindications to the use of restraint. These conditions should form part of the Child's Plan of Care.

Comment:

The jury wanted to emphasize the importance of considering the child's history and medical status and any contraindications to the use of restraint in the development of the child's care plan.

28. The Ministry of Community and Social Services should adequately fund the development of training curriculum for behavioural management intervention which emphasizes the best practices principle articulated by the Steering Committee on Behaviour Management Interventions for Children and Youth In Residential and Hospital Settings.

Comment:

The jury wanted to emphasize the importance of ensuring that the development of a behaviour management curriculum was appropriately funded to ensure that <u>all</u> workers within the group home industry were properly trained.

29. Any physician and consulting psychiatrist (if there is one) involved in the care of a child resident in a group home or other such facility should receive the full social and medical history of the child, and should be specifically consulted and have input into the formulation of the child's initial Plan of Care and receive copies of all subsequent Plans of Care on a timely basis.

Comment:

The jury wanted to emphasize the importance that all treating medical professionals were fully aware of the child's needs and had input into the child's plan of care.

30. An initial Plan of Care (i.e. created upon admission to a group home or other facility) should specifically address any recommendations made by any discharging facility relative to the child's subsequent care. Specific reasons should be given for any departure from such recommendations. Copies of Plans of Care, along with copies of documentation verifying the completion of any contemplated health initiatives, should be supplies by the service provider to the long term care Children's Aid Society worker having responsibility for the child in care.

Comment:

The jury wanted to emphasize the importance of documenting the rationale for any variation from previous treatment recommendations. In addition, the jury was of the opinion that the jurisdictional Children's Aid Society worker should be knowledgeable of the child's plan of care and any deviations from said plan.

31. **Long Term Care workers** should maintain, in the file of each child in care, a medical history, Special Incident Reports, Serious Occurrence Reports and Plans of Care, a check list of those medical and other initiatives to be undertaken in periods between Plans of Care together with documentation verifying the completion of such initiatives.

Comment:

The jury wanted to emphasize the importance of ensuring that the Children's Aid Society worker had a complete, documented record relevant to the care needs of the child in care.

32. Long Term Care workers should specifically review in Plans of Care any plans of action for behavioural management interventions and express agreement or disagreement with such plans or any modifications made to them.

Comment:

The jury wanted to ensure that the Children's Aid Society long term care worker was aware of the behaviour management interventions utilized in the management of their children.

33. Licensees compliance with provincial standards must be monitored through unscheduled visits by licensing officers and/or program supervisors from MCSS at different times of the day and week, including evening and weekends.

Comment:

The jury was advised that visits to group homes by Children's Aid Society workers and Ministry licensing officers were often scheduled in advance. The jury wanted to emphasize the importance of conducting unannounced visits as part of the monitoring process of group homes.

34. The prescribing physician should monitor children and youth that are placed on psychotropic drugs or a combination of drugs at frequent intervals. Where the prescribing physician delegates monitoring to another physician, there must be a timely, direct and complete exchange of information between the physicians.

Comment:

The jury wanted to stress the importance of ensuring that the monitoring of prescribed medications was clearly monitored by a specific physician.

35. To ensure real accountability and provide a high standard of care for children, provincial standards for residential care must be enforceable.

Comment:

The jury wanted to stress the importance of ensuring that provincial standards for residential care were enforceable.

36. MCSS should that child welfare agencies have a clear mandate and protocol to investigate child protection issues, including physical abuse and neglect, within institutions and residential service providers.

Comment:

Self explanatory.

37. The Ministry of Community and Social Services should make it a **mandatory** requirement that every person performing a **direct care** function in group homes and other facilities in the child care sector possess current certification in an accredited programme of **First Aid** and **Cardiopulmonary Resuscitation (CPR).**

Comment:

The jury wanted to emphasize the importance of ensuring that all group home workers having direct contact with children were certified in both first aid and CPR.

38. Following the recommendations of the Intersectorial Interministerial Steering Committee, the Ministry of Community and Social Services should lead in the development of a **standardized external training** programme for the behavioural management of children and youth in care.

Comment:

In this particular case, the group home workers received on-the-job internal training. The jury wanted to stress the importance of ensuring that all workers in the group home industry received standardized external training.

39. A standardized training curriculum, which incorporates a full range of behaviour management approaches and techniques, should be developed and implemented across the province, along with the requisite annual refresher training. The standardized training curriculum should reflect and incorporate the Best Practices Guidelines.

Comment:

To ensure that all group home workers in Ontario were appropriately trained, the jury wanted to stress the importance of ensuring that the training curriculum was standardized.

40. The Ministry of Community and Social Services should require that **staff employed in children's residences** are trained in the standard curriculum and behaviour management and receive the requisite refreshers.

Comment:

The jury wanted to emphasize the importance that all group home workers received standardized behaviour management training on an ongoing basis.

41. Child protection staff should receive training on the behaviour management interventions used with children in residential care pursuant to the Best Practices Guidelines, in order to enable them to interpret the Special Incident Reports received from resource providers.

Comment:

The jury wanted to stress the importance of ensuring that Children's Aid Society long term care workers were knowledgeable in behaviour management techniques so that they could interpret the information recorded in the Special Incident Reports.

42. Staff responsible for the care of children in residential placements should have a requisite standard level of education or training **prior to** caring for and treating children and youth. This training should include relevant college and/or university human services training programs or the equivalent, in addition to mandatory training in First Aid and cardiopulmonary resuscitation (CPR) specific to children.

Comment:

Given the complex needs of children in the group home industry, the jury was of the opinion that all workers in the industry should receive a basic requisite standard of training.

43. **Residential care providers** must ensure staff are knowledgeable in sound clinical interventions for vulnerable youth. Staff should be required to maintain and demonstrate a minimum of continuing education to address the complex needs of the children and youth in their care.

Comment:

This recommendation emphasizes the need for ongoing education for workers within the group home industry.

44. The Ministry of Community and Social Services should ensure adequate funding to licensees for the purpose of staff training and hold them accountable for the expenditure of funds for ongoing formalized training staff.

Comment:

This recommendation identifies the need to ensure that ongoing education for group home workers is appropriately funded and does not adversely impact on the day to day operation of the group home.

45. Licensing officers and program supervisors with the Ministry of Community and Social Services, and long term care workers/child protection workers of Children's Aid Societies, should have a basic level of training in respect of behaviour management interventions, First Aid and CPR, in order to adequately evaluate the programs and standard of care provided by licensed residential service providers.

Comment:

This recommendation identifies the importance of ensuring that licensing officers and program supervisors with the Ministry and Children's Aid Society workers are adequately trained in order that they can evaluate the programs and standards of care provided by group homes.

46. The Ministry of Community and Social Services should prohibit the **face-down-arms crossed over the chest restraint position.** Such a position is dangerous, life threatening and poses extreme risk of causing asphyxiation.

Comment:

The jury was of the view that the type of restraint used in this incident should be prohibited. The crossing of the child's arms in front of his chest would impair the child's inspiratory and expiratory movements of the chest wall.

The face down prone restraint with the weight of the restrainer over the child's waist line would cause pressure on the child's abdominal contents which would further impair the child's ability to breathe by limiting movement of the child's diaphragm.

47. There should be clearer direction on how restraints should be applied. An illustration booklet showing the proper step by step restraint procedure should be incorporated in all the residential care program manuals specifically stating:

    How restraints are to be used.

    How a child is moved from a sitting position to the floor restraint.

    Who should be doing the restraint.

    How many people should be involved in the restraint process.

    How to hold the child comfortably and safely.

    Monitoring the child.

Comment:

The jury was of the opinion that there should be an illustration book available to group home workers showing how to safely apply a restraint hold. Included in the book would be directions on how to monitor the child to ensure that the child was not getting into difficulty.

48. During any restraint the child's condition must be continually assessed, monitored and re-evaluated and the restriction of the child's movements or activity by restraint must be ended at the earliest possible time, considering the child's safety while being restrained.

Comment:

Again, the jury wanted to emphasize the importance of ensuring that the child was not getting into difficulty during the restraint.

49. **At all times**, two people should be involved during the application of a physical restraint, to ensure the child's condition is monitored and to apply the correct restraint in a safe and controlled manner.

Comment:

The jury was advised that any restraint should always be applied by two people to ensure the safety of the child.

50. The caregiver most familiar with the child's behavioural habits and who has the strongest relationship with the child should attempt to intervene and de-escalate a situation prior to a physical restraint.

Comment:

The jury believed that the caregiver most familiar with the child's behavioural habits was in the best position to intervene and de-escalate the situation in an attempt to prevent the application of a physical restraint.

51. The Ministry of Community and Social Services should require a standardized format for **Special Incident Reports** be utilized by all service providers. This standardized reporting **format** for Special Incidents should include information about:

    The reasons for/causes of the incident.

    The specific de-escalation attempts which were made and the effects of these.

    A detailed description of any application of force to a child (including removals and restraints); the mechanics of the application of force, the length of any restraint and the results of the application of force to be clearly identified.

    A history of any conversation between the child and persons involved in, or monitoring, the application of force.

    A complete record of any complaints made by the child prior to, during, or immediately following the application of force.

    A record of the specific steps taken to monitor the child during the application of force, including the tracking of pulse and respiration rates, skin colour and ability to engage in conversation.

    A detailed description of any change in the physical appearance or level of mental alertness/consciousness of the child AND the actions taken by staff to address such changes.

    Any injury however minor to the child.

    A notation that the service provider's medical practitioner has been informed concerning this application of force in a timely manner.

    A outline of the debriefing that subsequently took place (a) between supervisory staff and those members of staff involved with the application of force and its monitoring (b) between staff personnel and the child.

    An indication of any changes that are contemplated to the child's behavioural management program.

    An inclusion should be the attachment of the child's version of the event.

Comment:

The jury wanted to stress the importance of including all the above-noted clinical information on the Special Incident Report. Not only would this information be of value for the Ministry and Children's Aid Society supervisory personnel, but also the information would be invaluable to the group home workers in evaluating their behaviour management strategies for the individual child.

52. The Ministry of Community and Social Services should require that all incidents involving the application of force to a child by way of restraint be deemed to constitute an **"Occurrence"** for which a **Serious Occurrence Report** must be filed by the service provider.

    A copy of the full report is to be submitted to the Ministry of Community and Social Services Regional Office that exercises ministry licensing and supervisory responsibility over the service provider.

    A copy of the original full report is to be sent to a central repository of the Ministry.

    The Serious Occurrence reporting requirements should make it clear that ANY injury, however minor, that occurs in the course of a restraint must be reported as a Serious Occurrence.

Comment:

The jury was of the opinion that the application of force to a child was a serious matter that should be reported on a Serious Occurrence Report.

53. The Ministry of Community and Social Services should require a **standardized format** for the reporting of Serious Occurrences as defined in legislation. With respect to the application of a restraint, a format should be similar to that of the standardized Special Incident Report.

Comment:

Similar to the intent of recommendation #51, the jury wanted to stress the importance of including all the relevant clinical information relevant to the application of a restraint on the Serious Occurrence Report. Furthermore, the jury wanted to ensure that the required clinical information was enshrined in legislation.

54. The Ministry of Community and Social Services should require a **standardized format** for a **Plan of Care** to be utilized by all service providers. This standardized Plan of Care should include information about:

    Behavioural management/intervention plans of action to be followed.

    Description of those intervention approaches which were most effective in avoiding the application of force.

    Any contemplated modifications to intervention plans of action.

Specific subsections under the general heading of health indicating actions previously contemplated (medical checkups, blood tests, medication reviews, etc.) and the completion and overall result of such.

Comment:

The jury wanted to stress the importance of utilizing a standardized format in developing a child's Plan of Care.

55. Long Term Care workers and Children's Aid Societies should receive full copies of all **Special Incident Reports** and **Serious Occurrence Reports** generated by the service provider respecting children placed in care by their particular society. Copies of such reports should be received within one business day of the event having taken place.

Comment:

In an effort to ensure that supervising personnel within the Ministry and the Children's Aid Society were immediately advised of special incidents and serious occurrences relevant to a child, the jury believed that the information should be available to these supervisory personnel within one business day.

56. The Ministry of Community and Social Services should require that each service provider maintain roll ups of all usages and restraints described in the comprehensive and standardized Special Incident Reports. These summaries should be made available and be reviewed on a regular basis by Ministry licensing and program supervision personnel. The information would be considered in assessing compliance with policies and best practices guidelines with respect to behaviour management interventions and other licensing requirements.

Comment:

The jury believed that group home operators should maintain "roll ups" or reviews of all usages of restraints. These reviews would be invaluable not only in assessing the effectiveness of the group home's behaviour management program, but also in allowing the Ministry and Children's Aid Societies to assess compliance with policies and best practice guidelines.

57. The service provider shall forward to the Consulting Psychiatrist and Family Physician a copy of all Special Incident Reports where a restraint is used clearly indicating:

    Description of the restraint used.

    The physical effects if any on the child.

Comment:

The jury believed that the clinical information contained in the Special Incident Reports should be made available to the child's treating health care professionals.

58. The Ministry of Community and Social Services should more closely monitor serious occurrence reports and ensure that all placing agencies in the province have access to information in respect of the frequency of serious occurrences in residential placements.

Comment:

The jury believed that placing agencies should have access to information relevant to the frequency of serious occurrences in residential placements that were being considered for placement of a child.

59. The Ministry of Community and Social Services should take steps to create greater **pay equity** across the Child Care Sector to ensure that children and youth in group homes and other facilities have equal access to high quality care.

Comment:

The jury was advised that group home operators had difficulty in retaining group home workers because of the differential in pay scales for workers in group homes as opposed to workers in other areas of the child care sector. Equalization of the pay scales would go a long way in ensuring that the children in group homes had access to well trained and experienced workers.

60. The Ministry of Community and Social Services should undertake a fundamental review of the needs of group homes and residential settings with a view to ensuring that **adequate resources** are available to provide a high quality of care, support and treatment.

Comment:

The jury wanted to stress the importance of ensuring that group homes and residential settings throughout Ontario were fairly and adequately resourced.

In closing, I would like to again stress that the above synopsis and explanation of the recommendations was prepared solely to assist the reader in understanding the verdict. If any person feels that I have erred in my recollection of the evidence, I would be pleased to review my verdict explanation.

Yours truly,

Peter A. Clark, M.D.
Regional Supervising Coroner

PAC:ct