



Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The Coroners Act – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de St. Catharines, Ontario
 _____ of / de Grimsby, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famille Reid	Given Names / Prénoms Matthew David
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aged / à l'âge de 3 years / held at / tenue à Quality Hotel, St. Catharines, Ontario

from the / du 1st day of February to the / au 2nd day of March 20 10

By / Par Dr. / D^r James Edwards Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Matthew David Reid

Date and Time of Death / Date et heure du décès
December 15th 2005 @ 8:42am

Place of Death / Lieu du décès
Welland County General Hospital, Welland Ontario

Cause of Death / Cause du décès
Smothering by a pillow

By what means / Circonstances du décès
Homicide

ar les jurés

The verdict was received on the / Ce verdict a été reçu le 3 day of March 20 10
(Day / Jour) (Month / Mois)

Coroner's Name (Please print) / Nom du coroner (en lettres moulées) Dr. James Edwards, MD	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd) 2010/03/02
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[Signature]
Coroner's Signature / Signature du coroner

Received by the Office of
Dr. Bonita Porter
Deputy Chief Coroner - Inquests
MAR 3 - 2010
[Signature]

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)



Inquest into the death of:
Enquête sur le décès de :

Matthew David Reid

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

INQUEST TOUCHING THE DEATH OF MATTHEW REID

JURY RECOMMENDATIONS

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES (MCYS) OF ONTARIO:

- 1) It is recommended that the Ministry of Children and Youth Services strike a Task Force and/or Implementation Working Group to specifically consider and address the findings and recommendations of the jury in this inquest and, more generally, determine how best to avoid future similar deaths of children in care. The memory of Matthew Reid deserves no less. It is recommended that this Working Group include representatives from key stakeholder groups, which may include: the Ontario Association of Children's Aid Societies; the Chief Coroner's Paediatric Death Review Committee; Family and Children's services of Niagara; the Children's Aid Society of Haldimand-Norfolk; the organizations that represent children's aid society workers; and the Office of the Provincial Advocate for Children and Youth.
- 2) It is recommended that the Ministry of Children and Youth Services continue, and if feasible, accelerate, the development of a single information system for Child Welfare in the Province of Ontario which shall remain within the care and control of the Province of Ontario. Such a system should, among other features, provide child welfare workers quick access to key and relevant information that would inform critical decision making in the care and placement of children and service to families, and would allow for the timely sharing of information between agencies. This system would also help facilitate, among other things the current Ministry goals of creation of a single information system, strengthening youth voice, and building resilience. The system should include a capacity to perform keyword searches, be user friendly and contain a cumulative record of behavioural issues and concerns respecting the child.
- 3) It is recommended that irrespective of the development and implementation of a single information system, the Ministry of Children and Youth Services support a project to electronically image all historical paper and micro film of current and new cases of all Children Aid Societies in the province of Ontario.
- 4) It is recommended that the Ministry of Children and Youth Services provide discreet funding to children's aid societies for the purpose of securing the expertise of educational professionals to assist children or youth in care who have special educational needs or may be at risk for educational placement breakdown and ensuring the ease of transitions of children and youth from one educational environment to another.
- 5) It is recommended that the Ministry of Children and Youth Services conduct an audit of resources available to support children and families in the care of children's aid societies in Ontario. The audit should identify current service levels and gaps in services provided with a goal of ensuring the children of Ontario have an accessible and readily available integrated system of services. The audit should be performed in conjunction with stakeholders in the child welfare system, including youth, children's aid societies, children's mental health providers, school boards, developmental services and any other related child service providers. The government of Ontario should release for review and consideration any historical reports related to service levels which they have not released to date, including the "2005 Review of Residential Services" and "Mapping Children's Mental Health".
- 6) It is recommended that all Children Aid Societies should report annually on services being utilized to the Ministry of Children and Youth Services.
- 7) It is recommended that the Ministry of Children and Youth Services, in consultation with the child welfare sector, develop and implement a prescribed structured decision making eligibility framework for residential services.

This would be used by children's aid societies for the purposes of the identification and assessment of a child's needs for residential service, the level of care required, and the particular resource to be utilized.

8) It is recommended the Ministry of Children and Youth Services should conduct a review of the child welfare funding formula to ensure children's aid societies are adequately funded and have flexibility to better reflect the regional residential placement needs required by children in care.

9) It is recommended that sections 110 to 121 of Regulation 70 under the Child and Family Services Act be amended to include a requirement that an assessment of the child's behaviour which may present a risk of harm to any person, be conducted prior to the placement of that child in a foster home.

10) It is recommended that the Ministry of Child and Youth Services develop a mandatory "passport" for each child in the care of the Children's Aid Society. This "passport" shall accompany the child on all placements. The "passport" document shall include all information vital to the child's health, history and safety.

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES (MCYS) OF ONTARIO, TO THE ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES (OACAS), TO FAMILY AND CHILDREN'S SERVICES OF NIAGARA (FACS) AND TO THOSE CHILDREN'S AID SOCIETIES WHO CONSTITUTE THE FRONTLINE SYSTEM GROUP OF USERS:

11) It is recommended that any future system development in Child Welfare by the Ministry of Children and Youth Services, the Ontario Association of Children's Aid Societies or the Frontline users group include the capacity to perform a keyword search of all client records.

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES (MCYS) OF ONTARIO AND TO THE ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES (OACAS) :

12) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies work collaboratively with the Ontario Foster Parent Association and with Children's Aid Societies, at the appropriate level, to develop and fund outreach initiatives aimed at the recruitment and retention of appropriately qualified foster parents.

13) It is recommended that subsection 61 (7) of the Child and Family Services Act be reviewed, in consultation with the Ontario Association of Children's Aid Societies and other relevant stakeholders, to determine whether the two-year period of continuous residence should be reduced in recognition of the stability and connection experienced by children who have lived within the same home for a period of time sufficient to develop that stability and connection.

14) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies consult with youth and with Family and Children's Services Niagara (FACS) for the purpose of reviewing the content of the FACS memorandum dated January 25, 2008 regarding the addition of a ninth "Dimension" to a child's Plan of Care, entitled "Safety Considerations." The purpose of such a review would be to ensure that the children's aid societies across the province of Ontario undertake ongoing assessment and planning regarding safety issues related to children in care. MCYS and the OACAS should consider, as part of such review, whether MCYS should direct, whether by amending the "Ontario Looking After Children" (OnLAC) assessment and documentation system or otherwise, that all children's aid societies incorporate a "Dimension" into the Plan of Care similar to the internal policy developed by FACS.

15) It is recommended that the Ministry of Children and Youth Services' placement considerations be guided by the principle of ensuring that children have safe temporary placement options until such time as a full placement review has been conducted. In particular, emphasis should be put on exploring the feasibility of greater RAC availability (FACS Niagara's Regional Adolescent Centre, or similar facility) and an analysis of the merits of having a child remain in the current placement until a full placement review is conducted.

16) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies conduct a review of policies and procedures to develop standardized forms for commonly used documents. Looking forward to the requirements of a single information system, this would include, but not be limited to, intake forms, plans of care, child profiles, case notes, and placement forms.

17) It is recommended the Ministry of Children and Youth Services and Children's Aid Societies, in consultation with youth, develop best practice guidelines with regard to transitions from placement to placement respecting the importance of connection and relationship, the needs of the child, and the voice of the child. Guidelines should include that when a child is being placed in a new home, a Children's Service Worker, has made every attempt to involve the child and foster parent in salvaging the current placement and to minimize disruption. Once the move is decided, consideration must be given to the concerns and safety of any child affected by the proposed placement. The child's belongings and other transitional items (to make the child as comfortable as possible) should be assembled. Before

leaving a new placement, the care worker should speak to the child alone and create a safety plan should the child experience crisis. The worker should also inspect the child's room for suitability.

18) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies conduct, in consultation with youth, a review of the policies and procedures of children's aid societies concerning the placement of children into foster homes with a view to the creation of a model or "best practices" document that addresses the relevant factors that are to inform the selection of the most appropriate placement of a child from the available resources.

19) It is recommended the Ministry of Children and Youth Services, in consultation with youth with lived experience in the child welfare system, work with Children's Aid Societies to develop best practice guidelines that will enhance the voice of the child in all aspects of service delivery.

20) It is recommended Children's Aid Societies should ensure that discussions with young people regarding their wishes and views are clearly documented within the plan of care such that they are ascertainable and identifiable as being the child's wishes.

21) It is recommended Children's Aid Societies should develop, with the assistance of young people, "buddy systems" such that when a child enters the care system, the child should be paired with a youth, more experienced in the care system. The older youth can provide a support to the youth who is coming into care – somebody for them to talk to about their concerns, confusion, etc.

22) It is recommended that the Ministry of Children and Youth Services as well as the OACAS ensure that Outside Paid Resource (OPR) placements can occur on an emergency basis when necessary.

23) It is recommended that the CAS should review with its workers and supervisors the need for a thorough review of the case history when a case is transferred to a new worker and/or supervisor.

24) It is recommended that in the case of all paper files, (up to but not limited to family files, child in care files, adoption files etc.), a summary index page should be created and maintained as documents are added. When a file is closed, a copy should be added to any subsequent continuing client file.

TO THE ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES (OACAS):

25) It is recommended that the OACAS develop, in consultation with the Ontario Foster Parent Association a checklist of questions for prospective foster parents to ask when considering whether to accept a particular child or youth. This checklist should be included within the foster parenting manual provided by the local children's aid society.

26) It is recommended that unless it is impracticable to do so, given the emergent nature of the need for a foster home immediately, the prospective foster parent(s) be given a copy of the completed Placement Form before a child or youth is placed in the home.

27) It is Recommended that a placement team (appropriate decision maker(s) including case worker, supervisor, resource worker, foster parents, child in care) meeting occurs whenever there is an issue or concern expressed about residential placements.

28) It is recommended that the Ontario Association of Children's Aid Societies facilitate any revisions to the "Provincial Interagency Protocol between Children's Aid Societies" to incorporate the jury's recommendations as appropriate.

29) It is recommended that all shared resource policy and procedures should be revised such that only planned placements occur when sharing resources with another agency.

30) It is recommended that the OACAS develop a process of auditing the files of children in care including case notes of which all notes should be legible and preferably electronic.

31) It is recommended that a feasibility study be done regarding the placement of security systems in foster homes.

32) It is recommended that in foster homes caring for young children, the use of an electronic baby monitor in a child's bedroom be considered.

33) It is recommended that training and resources be provided by the agency for the foster parent regarding the parental controls on home computers.

TO FAMILY AND CHILDREN'S SERVICES OF NIAGARA (FACS):

34) It is recommended that the Society engage in a consultation with the Children's Aid Society of Haldimand-Norfolk for the purpose of discussing the matters learned from the evidence at this inquest and in order to discuss ways of collaborating effectively in the future, in the best interests of the children for whom both societies provide care.

TO THE CHILDREN'S AID SOCIETY OF HALDIMAND-NORFOLK:

35) It is recommended that Children's Aid Society of Haldimand-Norfolk continue to review the moratorium on placements from other children's aid societies, dated December 16, 2005, in light of subsequent developments, including the evidence heard at this inquest.

36) It is recommended that the Society engage in a consultation with Family and Children's Services of Niagara for the purpose of discussing the matters learned from the evidence at this inquest and in order to discuss ways of collaborating effectively in the future, in the best interests of the children for whom both societies provide care.

TO THE DISTRICT SCHOOL BOARD OF NIAGARA (DSBN):

37) It is recommended that the District School Board of Niagara continue to utilize the services of a Special Education Team ("wraparound team" as referred to in the evidence) in order to deal with the educational needs of difficult-to-serve students, including those who are in care of a children's aid society and/or present with special needs/developmental disabilities or where the appropriateness of the student's placement in the school is in question. Such a team should include someone knowledgeable about the workings of the Children's Aid Societies or a liaison person from FACS Niagara.

38) It is recommended that the District School Board of Niagara ensure that there is a comprehensive review of a student's needs, including measures previously adopted, in order to meet those needs, whenever preparations are being made to move a student into a regular school from a Section 23 (Education Act) class.

TO THE DISTRICT SCHOOL BOARD OF NIAGARA (DSBN), FAMILY AND CHILDREN'S SERVICES NIAGARA (FACS) AND NIAGARA CHILD AND YOUTH SERVICES (NCYS):

39) It is recommended that the District School Board of Niagara, Family and Children's Services of Niagara and Niagara Children and Youth Services continue to develop protocols for the sharing of information/reports in relation to the educational needs of children.

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES, MINISTRY OF HEALTH, ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES, FOSTER PARENT ASSOCIATIONS:

40) It is recommended that the Ministry of Children and Youth Services, in conjunction with other Ministries, including the Ministry of Health, supports training and addresses issues raised in the context of this inquest. The Ontario Association of Children's Aid Societies, and where applicable, Foster Parent Associations and the unions that represent front-line workers, need to strengthen the current mandatory and supplemental training to ensure they have the necessary skills and knowledge to provide quality care to the children entrusted to them, including but not limited to children that have special needs such as:

1. Running
2. Fetal Alcohol Spectrum Disorders (FASD), Fetal Alcohol Syndrome (FAS)
3. Developmental disabilities and delays
4. Dual Diagnosis children
5. Behavior Management Strategies
6. Children in crisis and transition
7. Interaction between children and the education system
8. Developing the child's plan of care
9. Developing the child's social history
10. Developing the child's life book

41) It is recommended that plans of care should include individualized behavior management intervention strategies that are consistent among all care providers (e.g., school, foster home, residential, treatment) for that child/youth. All deviation from the plan of care should be documented. This will assist with consistency in care for the child/youth and quality assurance.

42) It is recommended the Ministry of Children and Youth Services should conduct a comprehensive workload measurement study. The study would assess the impact of current legislative requirements and best practice implementation on workload with a goal of identifying reasonable workload/caseload bench marks to support the delivery of quality service to children and families.

TO THE MINISTRY OF HEALTH

43) It is recommended that the Ministry of Health launch a public information program to educate people about the consequences of alcohol consumption during pregnancy.

TO THE MINISTRY OF EDUCATION

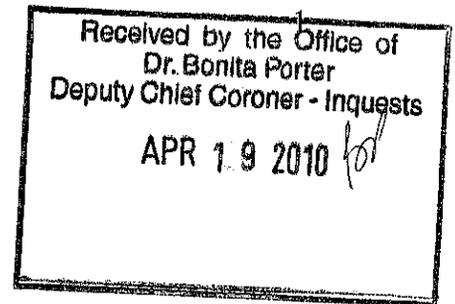
44) It is recommended that boards of education review practices related to suspensions. Considering children's rights develop a protocol for the management of children who are under suspension. In consideration of children's rights, boards of education should develop a protocol for the management of children who are under suspension.

45) It is recommended that the Ministry of Education undertake a review of the management of the child's "Ontario School Record" and "Central File" to ensure that the child's educational progress is informed by all relevant information and is easily accessible to the appropriate persons, particularly at key transitional points.

Personal information contained on this form is collected under the authority of the *Coroners Act*, R.S.O. 1990, C. C.37, as amended. Questions about this collection should be directed to the Chief Coroner, 26 Grenville St., Toronto ON M7A 2G9, Tel.: 416 314-4000 or Toll Free: 1 877 991-9959.

Les renseignements personnels contenus dans cette formule sont recueillis en vertu de la *Loi sur les coroners*, L.R.O. 1990, chap. C.37, telle que modifiée. Si vous avez des questions sur la collecte de ces renseignements, veuillez les adresser au coroner en chef, 26, rue Grenville, Toronto ON M7A 2G9, tél. : 416 314-4000 ou, sans frais : 1 877 991-9959.

VERDICT EXPLANATION



Name of the Deceased: Matthew Reid
Dates of Inquest: February 1st – March 2nd, 2010
Location of Inquest: Quality Inn, 327 Ontario Street
St. Catharines, Ontario

I intend to give a brief synopsis of the issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest, and is in no way intended to replace the jury's verdict.

Participants:

Counsel to the Coroner: Mr. Eric Siebenmorgen

Investigating Officers: Detective Constable Kevin Michener (# 9093) and
Constable Celine Whiteley (# 9066)
Niagara Regional Police Service
68 Church Street
St. Catharines, Ontario L2R 3C6

Coroner's Constable: Detective Constable Mike Langlais (# 9139)
Niagara Regional Police Service
68 Church Street
St. Catharines, Ontario L2R 3C6

Court Reporter: Ms. Eileen Wilson
Official Examiner's Office
The C.I.B.C. Building
Suite 401 – 55 King Street
P.O. Box 1388
St. Catharines, Ontario L2R 7J8
Telephone: (905) 687-8855

Parties with standing:

1. Ms. Margaret Hamilton
Represented by: Mr. Paul Osier
Arrell Law LLP
2 Caithness Street West
Caledonia, Ontario N3W 1C1

2. Children's Aid Society of Haldimand & Norfolk
Represented by: Mr. Wayne Herter
70 Town Centre Drive
Townsend, Ontario N0A 1S0
3. Ms. Violet McArthur
Self - represented
4. Ms. Tania Reid
Represented by: Ryan Steiner
Legate & Associates
150 Dufferin Avenue, Suite 302
London, Ontario N6A 5N6
5. District School Board of Niagara
Represented by: Ms. Sara Premi
Sullivan Mahoney LLP
40 Queen Street, P.O. Box 1360
St. Catharines, Ontario L2R 6Z2
6. Canadian Union of Public Employees Locals 1766 and 2328
Represented by: Mr. Paul O'Ryan and Mr. Jordan Goldblatt, respectively
Sack Goldblatt Mitchell LLP
20 Dundas Street West, Suite 1100
P.O. Box 180
Toronto, Ontario M5G 2G8
7. Family and Children's Services Niagara
Represented by: Mr. Michael D. Hartrick
Hartrick & Associates
Barristers & Solicitors
8 Price Street, Third Floor
Toronto, Ontario M4W 1ZA
8. L.B. (Young offender)
Self - represented
Chose to not participate in the inquest
9. Provincial Advocate for Children and Youth
Represented by: Ms. Suzan E. Fraser
Barrister & Solicitor
Old Bailey by the Park
112 Adelaide Street East
Toronto, Ontario M5C 1K9

Summary of the Circumstances of the Death:

Matthew Reid, three years of age, was a ward of the Children's Aid Society of Haldimand & Norfolk and resided in a foster home affiliated with that agency. The day before his death a fourteen year old ward of Family and Children's Services Niagara (FACS Niagara) was placed into the same residence. The next morning Matthew Reid was found in his bedroom with no vital signs. Resuscitative efforts were unsuccessful and he was pronounced dead in hospital. The fourteen year old subsequently plead guilty to suffocating him with a pillow, and was convicted as a young offender. The Office of the Chief Coroner decided to call a discretionary inquest into Matthew Reid's death.

The jury heard twelve days of evidence followed by summations, and then deliberated for five days before returning with its verdict. In total, thirty witnesses testified and seventy-six exhibits were introduced as evidence. There was testimony regarding the short life of Matthew Reid, matters relating to the fourteen year old young offender ("YO") (including the decision to place her into Matthew Reid's home, stresses on her, and her involvement with FACS Niagara, the District School Board of Niagara, health care providers and the justice system), the events on the day of the death, and the findings on postmortem examination. There was also evidence about the operations of Children's Aid Societies in Ontario (including their information systems, information provided to prospective foster parents, training and support of foster parents, decision making regarding residential placements, and legislation); practices followed by school boards in the province (including record keeping and educational placements), the effects of intrauterine exposure to alcohol, and issues relating to youth in care.

Verdict of Coroner's Jury:

The jury determined the following:

- | | |
|----------------------------|--|
| 1. Name of Deceased: | Matthew David Reid |
| 2. Date and Time of Death: | December 15, 2005, 8:42 a.m. |
| 3. Place of Death: | Welland County General Hospital, Welland,
Ontario |
| 4. Cause of Death: | Smothering by a pillow |
| 5. By what means: | Homicide |

Jury Recommendations:

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES (MCYS) OF ONTARIO:

- 1) It is recommended that the Ministry of Children and Youth Services strike a Task Force and/or Implementation Working Group to specifically consider and address the findings and recommendations of the jury in this inquest and, more generally, determine how best to avoid future similar deaths of children in care. The memory of Matthew Reid deserves no less.

It is recommended that this Working Group include representatives from key stakeholder groups, which may include: the Ontario Association of Children's Aid Societies; the Chief Coroner's Paediatric Death Review Committee; Family and Children's Services of Niagara; the Children's Aid Society of Haldimand-Norfolk; the organizations that represent children's aid society workers; and the Office of the Provincial Advocate for Children and Youth.

Coroner's Comments: The jury wanted a dedicated group of individuals from relevant agencies to work together to analyze their recommendations and develop strategies to prevent similar deaths in the future whenever possible.

2) It is recommended that the Ministry of Children and Youth Services continue, and if feasible, accelerate, the development of a single information system for Child Welfare in the Province of Ontario which shall remain within the care and control of the Province of Ontario. Such a system should, among other features, provide child welfare workers quick access to key and relevant information that would inform critical decision making in the care and placement of children and service to families, and would allow for the timely sharing of information between agencies. This system would also help facilitate, among other things, the current Ministry goals of creation of a single information system, strengthening youth voice, and building resilience. The system should include a capacity to perform keyword searches, be user friendly and contain a cumulative record of behavioral issues and concerns respecting the child.

Coroner's Comments: The jury heard evidence that many of the records for children in care in Ontario are paper files, which may be voluminous and difficult to read, and that it is sometimes difficult for child welfare workers to readily obtain relevant information. In addition, the absence of a standard information system for Children's Aid Societies across the province can impede the timely sharing of information between agencies. This recommendation is intended to promote the capture, preservation, retrieval and sharing of information to provide workers with ready access to the information required to make decisions regarding children in care.

3) It is recommended that irrespective of the development and implementation of a single information system, the Ministry of Children and Youth Services support a project to electronically image all historical paper and micro film of current and new cases of all Children Aid Societies in the province of Ontario.

Coroner's Comments: This recommendation is intended to ensure that the information presently stored on paper or microfilm is converted into electronic form to make it more readily available to child care workers.

4) It is recommended that the Ministry of Children and Youth Services provide discreet funding to Children's Aid Societies for the purpose of securing the expertise of educational professionals to assist children or youth in care who have special educational needs or may be at risk for educational placement breakdown and ensuring the ease of transitions of children and youth from one educational environment to another.

Coroner's Comments: The jury heard evidence that YO had been functioning well in a day treatment program at the District School Board of Niagara, but had difficulty adapting to the regular school program where she was subsequently transferred. This recommendation is intended to ensure that children in care are placed in optimal educational environments and receive assistance during the transition from one educational placement to another.

5) It is recommended that the Ministry of Children and Youth Services conduct an audit of resources available to support children and families in the care of Children's Aid Societies in Ontario. The audit should identify current service levels and gaps in services provided with a goal of ensuring the children of Ontario have an accessible and readily available integrated system of services. The audit should be performed in conjunction with stakeholders in the child welfare system, including youth, Children's Aid Societies, children's mental health providers, school boards, developmental services and any other related child service providers. The government of Ontario should release for review and consideration any historical reports related to service levels which they have not released to date, including the "2005 Review of Residential Services" and "Mapping Children's Mental Health".

Coroner's Comments: The jury wanted an audit of available resources for the provision of services to children and families in care in Ontario, and an allocation of additional resources whenever deficiencies are identified.

6) It is recommended that all Children's Aid Societies should report annually on services being utilized to the Ministry of Children and Youth Services.

Coroner's Comments: This recommendation is intended to ensure that the Ministry of Children and Youth Services is made aware of the needs of Children's Aid Societies.

7) It is recommended that the Ministry of Children and Youth Services, in consultation with the child welfare sector, develop and implement a prescribed structured decision making eligibility framework for residential services. This would be used by Children's Aid Societies for the purposes of the identification and assessment of a child's needs for residential service, the level of care required, and the particular resource to be utilized.

Coroner's Comments: There was evidence about the decision to place YO in Matthew Reid's foster home. The jury wanted a standard process regarding the residential placement of children in care in Ontario to ensure effective and consistent decision making.

8) It is recommended the Ministry of Children and Youth Services should conduct a review of the child welfare funding formula to ensure Children's Aid Societies are adequately funded and have flexibility to better reflect the regional residential placement needs required by children in care.

Coroner's Comments: The jury wanted a review to determine whether Children's Aid Societies receive sufficient funding to pay for residential placements of children in care, recognizing that needs will vary from region to region and that flexibility is required.

9) It is recommended that sections 110 to 121 of Regulation 70 under the Child and Family Services Act be amended to include a requirement that an assessment of the child's behavior which may present a risk of harm to any person, be conducted prior to the placement of that child in a foster home.

Coroner's Comments: There was no specific assessment of the risk which YO may have posed to Matthew Reid before she was placed in his home. The jury felt that such assessments should be conducted before future residential placements of children in care.

10) It is recommended that the Ministry of Child and Youth Services develop a mandatory "passport" for each child in the care of the Children's Aid Society. This "passport" shall accompany the child on all placements. The "passport" document shall include all information vital to the child's health, history and safety.

Coroner's Comments: The jury heard evidence that Matthew Reid's foster mother made inquiries about his safety before agreeing to accept YO into her home, and that she was not provided with written material to assist with this decision. The recommended passport would be provided to prospective foster parents across the province and contain information to assist them to make informed decisions in these situations.

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES (MCYS) OF ONTARIO, TO THE ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES (OACAS), TO FAMILY AND CHILDREN'S SERVICES OF NIAGARA (FACS) AND TO THOSE CHILDREN'S AID SOCIETIES WHO CONSTITUTE THE FRONTLINE SYSTEM GROUP OF USERS:

11) It is recommended that any future system development in Child Welfare by the Ministry of Children and Youth Services, the Ontario Association of Children's Aid Societies or the frontline users group include the capacity to perform a keyword search of all client records.

Coroner's Comments: The information storage systems (particularly paper and microfilm records) currently used by Children's Aid Societies in Ontario often do not allow keyword searches. The jury felt that keyword searches are important to allow for the timely retrieval of relevant information, particularly when making risk assessments during residential placements.

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES (MCYS) OF ONTARIO AND TO THE ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES (OACAS):

12) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies work collaboratively with the Ontario Foster Parent Association and with Children's Aid Societies, at the appropriate level, to develop and fund outreach initiatives aimed at the recruitment and retention of appropriately qualified foster parents.

Coroner's Comments: The jury heard evidence that foster parents are an important component of the residential placement system for children in care in Ontario. However, for a number of reasons, there is now a shortage of qualified foster parents in parts of the province, including the two Children's Aid Societies involved in this inquest. This recommendation is intended to ensure an adequate number of qualified foster parents.

13) It is recommended that subsection 61 (7) of the Child and Family Services Act be reviewed, in consultation with the Ontario Association of Children's Aid Societies and other relevant stakeholders, to determine whether the two-year period of continuous residence should be reduced in recognition of the stability and connection experienced by children who have lived within the same home for a period of time sufficient to develop that stability and connection.

Coroner's Comments: Subsection 61 (7) of the Child and Family Services Act provides foster parents with whom a child in care has lived for two years with the right to apply for a review of any proposed removal of the child from their home. While there was evidence that YO had a stable and strong relationship with the foster family with whom she lived before being placed in Matthew Reid's home, that family was not provided with the opportunity to contest her removal from their home because they had been living together for just under two years. This recommendation was made in recognition of the strong and positive relationship that may exist between children in care and foster parents who have lived together for less than two years.

14) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies consult with youth and with Family and Children's Services Niagara (FACS) for the purpose of reviewing the content of the FACS memorandum dated January 25, 2008 regarding the addition of a ninth "Dimension" to a child's Plan of Care, entitled "Safety Considerations." The purpose of such a review would be to ensure that the Children's Aid Societies across the province of Ontario undertake ongoing assessment and planning regarding safety issues related to children in care. MCYS and the OACAS should consider, as part of such review, whether MCYS should direct, whether by amending the "Ontario Looking After Children" (OnLAC) assessment and documentation system or otherwise, that all children's aid societies incorporate a "Dimension" into the Plan of Care similar to the internal policy developed by FACS.

Coroner's Comments: After the death of Matthew Reid, FACS Niagara incorporated the dimension of "Safety Considerations" into the assessment and management of children in their care. This recommendation is intended to encourage the use of this model across Ontario.

15) It is recommended that the Ministry of Children and Youth Services' placement considerations be guided by the principle of ensuring that children have safe temporary placement options until such time as a full placement review has been conducted. In particular, emphasis should be put on exploring the feasibility of greater RAC availability (FACS Niagara's Regional Adolescent Centre, or similar facility) and an analysis of the merits of having a child remain in the current placement until a full placement review is conducted.

Coroner's Comments: There was evidence that YO had a very positive relationship with the foster family with which she lived before being placed in Matthew Reid's home, and the jury wanted to encourage an exploration of the option of keeping children in their current placements until a placement review is completed. There was also evidence that, while temporary placement in FACS Niagara's Regional Adolescent Centre may provide time for a full placement review to take place, it is often not available to children such as YO because its capacity is limited. The jury wanted an exploration of expanding the availability of similar facilities across Ontario.

16) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies conduct a review of policies and procedures to develop standardized forms for commonly used documents. Looking forward to the requirements of a single information system, this would include, but not be limited to, intake forms, plans of care, child profiles, case notes, and placement forms.

Coroner's Comments: There was evidence that the content and layout of documents used by Children's Aid Societies across the province varies from one agency to the next. The jury felt that high quality and consistent documentation would promote effective information sharing between agencies.

17) It is recommended the Ministry of Children and Youth Services and Children's Aid Societies, in consultation with youth, develop best practice guidelines with regard to transitions from placement to placement respecting the importance of connection and relationship, the needs of the child, and the voice of the child. Guidelines should include that when a child is being placed in a new home, a Children's Service Worker, has made every attempt to involve the child and foster parent in salvaging the current placement and to minimize disruption. Once the move is decided, consideration must be given to the concerns and safety of any child affected by the proposed placement. The child's belongings and other transitional items (to make the child as comfortable as possible) should be assembled. Before leaving a new placement, the care worker should speak to the child alone and create a safety plan should the child experience crisis. The worker should also inspect the child's room for suitability.

Coroner's Comments: There was evidence about the importance to youth of relationships, connection, stability, and having a voice in their affairs. The jury wanted to encourage the maintenance of current placements whenever possible, and the institution of measures to minimize disruption and promote safety whenever this is not feasible.

18) It is recommended that the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies conduct, in consultation with youth, a review of the policies and procedures of Children's Aid Societies concerning the placement of children into foster homes with a view to the creation of a model or "best practices" document that addresses the relevant factors that are to inform the selection of the most appropriate placement of a child from the available resources.

Coroner's Comments: The jurors wanted to encourage the development and implementation of an optimal process for the placement of children in foster homes across Ontario. They felt that

young people should be included in this process in recognition of the importance of providing them with a voice in their own affairs.

19) It is recommended the Ministry of Children and Youth Services, in consultation with youth with lived experience in the child welfare system, work with Children's Aid Societies to develop best practice guidelines that will enhance the voice of the child in all aspects of service delivery.

Coroner's Comments: This recommendation is also based on evidence about the importance of providing young people with a voice in their own affairs.

20) It is recommended that Children's Aid Societies should ensure that discussions with young people regarding their wishes and views are clearly documented within the plan of care such that they are ascertainable and identifiable as being the child's wishes.

Coroner's Comments: The jury heard evidence that there was some uncertainty about YO's wishes and views in regard to her residential placement shortly before the death of Matthew Reid. This recommendation is intended to ensure that the Children's Aid Society documentation accurately captures and reflects the child's perspective.

21) It is recommended Children's Aid Societies should develop, with the assistance of young people, "buddy systems" such that when a child enters the care system, the child should be paired with a youth, more experienced in the care system. The older youth can provide a support to the youth who is coming into care – somebody for them to talk to about their concerns, confusion, etc.

Coroner's Comments: The jurors heard evidence about the importance which YO placed on her social network. They also heard about the value of peers as a source of support and advice to young people, and challenges posed by transitions such as residential changes. This recommendation is intended to provide children with a specific comrade to provide assistance, comfort, and support in difficult times.

22) It is recommended that the Ministry of Children and Youth Services as well as the OACAS ensure that Outside Paid Resource (OPR) placements can occur on an emergency basis when necessary.

Coroner's Comments: The jury heard evidence that FACS Niagara needed to find a residential placement for YO quickly because she was being held in custody, and that an OPR placement was not feasible because of the time required to schedule a meeting to approve this option. FACS Niagara has since taken steps to expedite the process for arranging OPR placements. This recommendation is intended to provide the other Children's Aid Societies in Ontario with a similar mechanism for approving OPR placements on an emergency basis when required.

23) It is recommended that the CAS should review with its workers and supervisors the need for a thorough review of the case history when a case is transferred to a new worker and/or supervisor.

Coroner's Comments: The jury heard evidence about the transfer of YO's file from her previous case worker to the worker she had at the time of Matthew Reid's death. This recommendation is intended to ensure that sure transfers include a comprehensive review of the case.

24) It is recommended that in the case of all paper files, (up to but not limited to family files, child in care files, adoption files etc.), a summary index page should be created and maintained as documents are added. When a file is closed, a copy should be added to any subsequent continuing client file.

Coroner's Comments: The jury heard evidence that the FACS Niagara record on YO contained many files. This recommendation is intended to create a mechanism for capturing the relevant information in each file and transferring it to subsequent ones.

TO THE ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES (OACAS):

25) It is recommended that the OACAS develop, in consultation with the Ontario Foster Parent Association a checklist of questions for prospective foster parents to ask when considering whether to accept a particular child or youth. This checklist should be included within the foster parenting manual provided by the local Children's Aid Society.

Coroner's Comments: The jury heard evidence that Matthew Reid's foster mother made inquiries about his safety before agreeing to accept YO as a foster child in her home. This recommendation is intended to provide prospective foster parents across Ontario with written documentation to assist with such decision making.

26) It is recommended that unless it is impracticable to do so, given the emergent nature of the need for a foster home immediately, the prospective foster parent(s) be given a copy of the completed Placement Form before a child or youth is placed in the home.

Coroner's Comments: This recommendation is also intended to provide prospective foster parents with documentation to assist them in deciding whether to accept a foster child into their homes.

27) It is recommended that a placement team (appropriate decision maker(s) including case worker, supervisor, resource worker, foster parents, child in care) meeting occurs whenever there is an issue or concern expressed about residential placements.

Coroner's Comments: YO's case worker made the decision to remove her from the foster home in which she had been residing because of concerns that she would run away again. The jury wanted a team, rather than an individual, to make such decisions in the future.

28) It is recommended that the Ontario Association of Children's Aid Societies facilitate any revisions to the "Provincial Interagency Protocol between Children's Aid Societies" to incorporate the jury's recommendations as appropriate.

Coroner's Comments: The "Provincial Interagency Protocol between Children's Aid Societies" describes the process to be used when children in care are transferred from one Children's Aid Society to another. The jury wanted amendments to this document to reflect their recommendations.

29) It is recommended that all shared resource policy and procedures should be revised such that only planned placements occur when sharing resources with another agency.

Coroner's Comments: There was evidence that the decision to place YO (who was in the care of FACS Niagara) in a Haldimand-Norfolk CAS foster home was urgent because she was in custody at the time. The jury wanted future interagency placements to occur only when they are planned in advance. This would allow time for consultation and information sharing between the two agencies.

30) It is recommended that the OACAS develop a process of auditing the files of children in care including case notes of which all notes should be legible and preferably electronic.

Coroner's Comments: This recommendation is based on evidence that the FACS Niagara record for YO contained many handwritten case notes, and that it could be difficult to obtain relevant information from this material in a timely manner. The jury wanted legible handwritten case notes or, better yet, the electronic storage of case notes. The electronic storage of information would also permit key word searches.

31) It is recommended that a feasibility study be done regarding the placement of security systems in foster homes.

Coroner's Comments: This recommendation was made to address evidence that YO ran away from her foster home.

32) It is recommended that in foster homes caring for young children, the use of an electronic baby monitor in a child's bedroom be considered.

Coroner's Comments: This recommendation is based on evidence that YO entered Matthew Reid's bedroom and smothered him with a pillow.

33) It is recommended that training and resources be provided by the agency for the foster parent regarding the parental controls on home computers.

Coroner's Comments: There was evidence that fourteen year old YO ran away from her foster home after using a home computer to make questionable internet contacts. This

recommendation is intended to allow foster parents to monitor and control the internet use of children in their care.

TO FAMILY AND CHILDREN'S SERVICES OF NIAGARA (FACS):

34) It is recommended that the Society engage in a consultation with the Children's Aid Society of Haldimand-Norfolk for the purpose of discussing the matters learned from the evidence at this inquest and in order to discuss ways of collaborating effectively in the future, in the best interests of the children for whom both societies provide care.

Coroner's Comments: This recommendation is intended to encourage ongoing communication and collaboration between the two Children's Aid Societies involved in this inquest.

TO THE CHILDREN'S AID SOCIETY OF HALDIMAND-NORFOLK:

35) It is recommended that Children's Aid Society of Haldimand -- Norfolk continue to review the moratorium on placements from other Children's Aid Societies, dated December 16, 2005, in light of subsequent developments, including the evidence heard at this inquest.

Coroner's Comments: The jury heard evidence that Haldimand -- Norfolk CAS continues to maintain the moratorium on outside placements instituted after the death of Matthew Reid. This recommendation is intended to encourage a reconsideration of the need for this moratorium and promote the sharing of resources between Children's Aid Societies.

36) It is recommended that the Society engage in a consultation with Family and Children's Services of Niagara for the purpose of discussing the matters learned from the evidence at this inquest and in order to discuss ways of collaborating effectively in the future, in the best interests of the children for whom both societies provide care.

Coroner's Comments: This recommendation is also intended to promote ongoing communication and collaboration between the two Children's Aid Societies involved in this inquest.

TO THE DISTRICT SCHOOL BOARD OF NIAGARA (DSBN):

37) It is recommended that the District School Board of Niagara continue to utilize the services of a Special Education Team ("wraparound team" as referred to in the evidence) in order to deal with the educational needs of difficult-to-serve students, including those who are in care of a Children's Aid Society and/or present with special needs/developmental disabilities or where the appropriateness of the student's placement in the school is in question. Such a team should include someone knowledgeable about the workings of the Children's Aid Societies or a liaison person from FACS Niagara.

Coroner's Comments: There was evidence about decision making by the District School Board of Niagara regarding YO's educational placement, and her difficulty adapting to the school program to which she was transferred. The jury wanted to encourage the continued use of the Special Education Team established by the District School Board of Niagara after the death of Matthew Reid to deal with similar situations in the future.

38) It is recommended that the District School Board of Niagara ensure that there is a comprehensive review of a student's needs, including measures previously adopted, in order to meet those needs, whenever preparations are being made to move a student into a regular school from a Section 23 (Education Act) class.

Coroner's Comments: There was evidence that YO was doing well in a special needs class that had features such as enhanced supervision, and that she had difficulty adapting to the regular school program where she was transferred. To ensure a smooth transition, the jury wanted a review of students' needs and previous educational interventions prior to such transfers in the future.

TO THE DISTRICT SCHOOL BOARD OF NIAGARA (DSBN), FAMILY AND CHILDREN'S SERVICES NIAGARA (FACS) AND NIAGARA CHILD AND YOUTH SERVICES (NCYS):

39) It is recommended that the District School Board of Niagara, Family and Children's Services of Niagara and Niagara Children and Youth Services continue to develop protocols for the sharing of information/reports in relation to the educational needs of children.

Coroner's Comments: The results of a series of psychometric tests performed on YO for FACS Niagara were shared with her foster family, child welfare workers, and the day treatment educational program in which she was enrolled at the time. However, these reports were not provided to the high school which YO later attended. This recommendation is intended to promote the sharing of information between agencies involved in the provision of services to children.

TO THE MINISTRY OF CHILDREN AND YOUTH SERVICES, MINISTRY OF HEALTH, ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES, FOSTER PARENT ASSOCIATIONS:

40) It is recommended that the Ministry of Children and Youth Services, in conjunction with other Ministries, including the Ministry of Health, supports training and addresses issues raised in the context of this inquest. The Ontario Association of Children's Aid Societies, and where applicable, Foster Parent Associations and the unions that represent front-line workers, need to strengthen the current mandatory and supplemental training to ensure they have the necessary skills and knowledge to provide quality care to the children entrusted to them, including but not limited to children that have special needs such as:

1. Running
2. Fetal Alcohol Spectrum Disorders (FASD), Fetal Alcohol Syndrome (FAS)

3. Developmental disabilities and delays
4. Dual Diagnosis children
5. Behavior Management Strategies
6. Children in crisis and transition
7. Interaction between children and the education system
8. Developing the child's plan of care
9. Developing the child's social history
10. Developing the child's life book

Coroner's Comments: The jury wanted to ensure that every person involved in the child welfare sector receives comprehensive training in the above listed subjects explored at this inquest.

41) It is recommended that plans of care should include individualized behavior management intervention strategies that are consistent among all care providers (e.g., school, foster home, residential, treatment) for that child/youth. All deviation from the plan of care should be documented. This will assist with consistency in care for the child/youth and quality assurance.

Coroner's Comments: The jury heard evidence about the importance of consistency in the provision of services to children and youth.

42) It is recommended the Ministry of Children and Youth Services should conduct a comprehensive workload measurement study. The study would assess the impact of current legislative requirements and best practice implementation on workload with a goal of identifying reasonable workload/caseload bench marks to support the delivery of quality service to children and families.

Coroner's Comments: The jury wanted a study to determine whether the workload of workers in the child welfare sector is consistent with the provision of quality services.

TO THE MINISTRY OF HEALTH

43) It is recommended that the Ministry of Health launch a public information program to educate people about the consequences of alcohol consumption during pregnancy.

Coroner's Comments: This recommendation is based on evidence that YO exhibited behavior consistent with intrauterine exposure to alcohol. The jury wanted to promote public awareness of the risks associated with alcohol consumption during pregnancy.

TO THE MINISTRY OF EDUCATION

44) It is recommended that boards of education review practices related to suspensions. In consideration of children's rights, boards of education should develop a protocol for the management of children who are under suspension.

Coroner's Comments: This recommendation is based on evidence that YO had been suspended from school and was on home instruction for several weeks at the time of Matthew Reid's death, and that this absence from the school environment affected her adversely. The jury wanted a protocol dealing with the needs of children who have been suspended from school.

45) It is recommended that the Ministry of Education undertake a review of the management of the child's "Ontario School Record" and "Central File" to ensure that the child's educational progress is informed by all relevant information and is easily accessible to the appropriate persons, particularly at key transitional points.

Coroner's Comments: There was evidence that the Ontario School Record and Central File contain different material. The jury wanted a review of the contents of these documents to ensure that relevant information is readily available to decision makers.

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that it is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.



James Edwards, M.D.
Presiding Coroner
April 16, 2010