Office of the Chief Coroner

VERDICT OF CORONER'S JURY

Q2002-48.

We

___	of	Oakville
___	of	Milton
___	of	Milton
___	of	Oakville
___	of	Milton

the jury serving on the inquest into the death of:

Surname: Rosales Given Names: Paola

aged: 14 held at: Oakville and Milton (Halton Region)

on the 16 – 30 September, 1 –11,21-31 October and 1 November Day(s) of 2002

by: Dr. C. RATHWELL Coroner for Ontario

1. Name of deceased: **Paola Rosales**
2. Date and time of death: **July 3, 2001 13:00 hours**
3. Place of death: **Hospital for Sick Children Critical Care Unit, in Toronto, Ontario**
4. Cause of death: **Delayed hanging**
5. By What means: **Suicide**

(Continue on page 2 if necessary)

Regional Supervising Coroner

Signatures of Jurors

This Verdict was received by me this first day of November 2002.

Signature of Coroner

Distribution Original - Regional Coroner for forwarding to Chief Coroner Copy - Crown Attorney

CC 010 (Rev 06/89 09/05/96 Word)

We wish to make the following recommendations:

Communication

1. We recommend that the Children's Aid Society (CAS) case worker immediately file a form 14 and provide pertinent background information to any medical professional who comes in contact with the child.

   We recommend that the college of Physicians and Surgeons direct the medical professional or facility who receives the form 14 to provide the entire record, with an explanation for any excluded portions of the child's record. We recommend that the information from the form 14 be provided within 5 working days.

   Reason: Full records often contain important additional information, which may be helpful to subsequent treatment providers. If this information is left out then the diagnosis could be incorrect and inappropriate treatment given.

2. We recommend that the Ministry of Community, Family and Child Services (MCFCS) develop a mandatory one or two page "passport" to be sent immediately for each child in the care of a children's aid society (CAS). No child will be accepted by placement without this passport. It should be sent as well to appropriate medical practitioners

   A secondary detailed package is to follow with in two working days.

   The Immediate passport document shall set out, in concise form, information which is vital to the child's health and safety including information pertaining to the child's past history of suicide attempts;

   - current psychiatric diagnoses;
   - any history of suicide or depression;
   - any history of violence and / or AWOL behaviours;
   - a list of the child's medications, dates and refill;
   - any known medical conditions or allergies;
   - the names and phone numbers of any health professionals who are currently involved in treating the child.
   - family contact where no protection issues

   In addition, the passport shall set out the name, phone and fax numbers of the child's assigned worker as well as the phone number for the society's after hour's service. The document shall include a list of any family members with whom the child is permitted contact.

   The Secondary Package with a complete detailed package of all vital information including the following:

   - Detailed reason for CAS care
   - Form 14

- Full doctors report
- Complete school records
- Complete family medical history

Reason: To assure the ability to care for the safety and security of a child.

3. We recommend to the MCFCS that the CAS worker assigned to the child is accountable for all flow of information to all caregivers and community services who are in contact with the child while in the care of the CAS. This includes any facility, detention center or jail. It is preferable to use hard copy form as the formal means of communication.

   Reason: Verbal communication often breaks down.

4. We recommend to the MCFCS that the CAS worker be required to speak frequently enough with a child within the first 72 hours of placement to ensure that their needs are being met and their concerns are addressed.

   Reason: The first 48 – 72 hours is when the child is most at risk

5. We recommend the MCFCS implement a policy that requires all Children's Aid Society night duty workers to have access to the CAS Worker files. All CAS Workers must have an updated passport for each child available to night duty workers.

   Reason: Some of the CAS night duty workers do not have access to this information.

6. We recommend the MCFCS implement a policy requiring the CAS to provide access to legal council for a child whom becomes involved with the Young Offenders Act. This includes attending each and every court appearance. Where there are no protection concerns, parents should be encouraged to attend court to support the youth.

   Reason: Children often do not know their legal rights and the children need support.

7. We recommend MCFCS implement a policy requiring the initial CAS plan of care meeting to be held within the first week of placement. CAS worker must bring the child's file to all meetings and have foreign language worker present to translate if required. As part of the plan of care, telling the child and parents about child advocates office and an explanation of the residential placement advisory committee process (RPAC) must be done.

   All plan of care meetings must result in documented minutes that are signed by all parties. The participants should include doctors, child, caregiver, home manager and parents where applicable. Assigned tasks must be followed up on within 24 hours.

   Reason: This is necessary to ensure that everyone involved understands the plan and what is expected to happen, especially that the child knows they are cared for and have some control over their life.

Training

8. We recommend the MCFCS implement a policy requiring all children aid society workers, all foster parents, all staff employed in youth correctional facilities be required to participate in intensive training in the areas of suicide risk identification, assessment and prevention, behaviour management, and prevention, Young Offenders Act and Mental Health Act

   Foster parents, correctional staff and CAS workers must be tested regularly as to their knowledge of the indicators associated with heightened risk of suicidality.

   MCFCS allocate additional funding without affecting other ministry programs.

   Reason: Provide a solid base of important common knowledge for all staff to protect children who enter the child care system.

9. We recommend that the Ministry of Training, Colleges and Universities provide direction to all provincial Community Colleges offering the diploma programs of Child and Youth Worker and Correctional Worker that the curricula of those programs be amended to include substantial course work addressing the identification, assessment, management and prevention of suicidal risk, ideation and behaviours in adolescents, with particular emphasis on the needs and risks of Young People in the Young Offender system; and on the identification and assessment of abnormal adolescent psychology, with emphasis on adolescent depression and the criteria for referral to clinical services.

   Reason: In the course of their employment, these workers encounter increased numbers of youths who are at risk of suicidal behaviour, and the curriculum should reflect the changes in our Society.

10. We recommend the federal and provincial Ministries of Health allocate additional resources for:

    - The establishment of both inpatient and community-based psychiatric programs for youths.
    - The number of applicants for psychiatric residency programs doubles the number of positions available. We recommend additional funding to hospitals and universities so as to permit a greater number of adolescent psychiatrists to be trained and qualified in the province
    - In the case of children in the care of a children's aid society, we recommend the compensation child psychiatrists for their attendance at case plan or case conference meetings

    Reason: In the Mental Health system at present, there is a dearth of both inpatient and outpatient psychiatric services for adolescents in this province. If adolescent suicide is to be prevented, it is imperative this deficiency be rectified as soon as possible.

11. We recommend the MCFCS, in conjunction with the provinces' children's aid societies, develop strategies for recruiting foster parents, particularly in the GTA. We recommend a study of the per diem rates as an incentive to recruit more foster care homes.

    Reason: There is a dearth of suitable foster homes in the province, particularly in the Greater Toronto Area. As a result, children are often placed in foster homes far from their families and friends, this is an important factor in the mental health of a child.

12. We recommend the MCFCS adopt a standardized contract which clearly outlines each parties responsibilities to be used between all CAS agencies and residential placement. The contract must be signed before any children are placed with that facility.

    Reason: This will provide an efficient mechanism to define responsibilities and expectations of the out placement facilities.

13. We recommend MCFCS provide a secure web site that contains the detailed status of the licenses of all residential foster and group homes and any "serious occurrence" reports for all CAS agencies to access.

    Reason: The current ministry information is not readily accessible to the CAS to make appropriate judgments about placements.

14. We recommend that the Ministry of Health prepare amendments to the Mental Health Act to have separate criteria for involuntary admittance of adolescents vs adults.

    Reason: The characteristics or adolescent mental problems differ significantly from those of adults.

15. We recommend to the Ministry of Corrections that suicidal tendancies should be a separate criteria for a provincial director to level determine an adolescent for a secure facility with clinicians on staff if applicable to that youth.

    Reason: It has become apparent that there is inadequate ability to keep safe the youth in open detention facilities.

16. We recommend the MCFCS and the Ministry of Corrections put a policy in place that all incident reports be faxed immediately (within 24 hours) upon completion to the CAS worker for any children in care.

    Reason: This is required for the flow of information to support the CAS program.

17. We recommend the Ministry of Health catchments area policy have a clause allowing access to a previous mental health medical professional if deemed necessary.

    Reason: Promotes consistency and stability for the child in dealing with mental health professionals.

18. We recommend the Ontario Association of Children Aid Societies publish jury recommendations and disseminate to facilities and agencies.

19. We recommend the Ministry of Health stipulate that no medical facility can deny or refuse treatment to youth in a young offender facility. We also recommend that MCFCS and Ministry of Public Safety and Security (MPSS) provide funding for open detention and open custody facilities for young persons in order to secure clinical support for young persons suffering from depression and suicidal ideation.

    Reason: It was noted that these facilities have a great difficulty providing these services for young persons.

20. MCFCS amd MPSS should create an independent, autonomous regulatory body as an external quality assurance mechanism responsible for:

    - the licensing of facilities
    - the ongoing development and revision of service delivery standards and best practices focused on client outcomes and results
    - providing direction to individual facilities on policies and procedures that may be required to meet provincial standards
    - Accountability for the investigation of serious occurrences and, where appropriate, the development of strategies and action plans for corrective action
    - Setting standards for staff qualifications and training expectations
    - Guideline for acceptable forms of windows coverings
    - Mandatory safety inspection and consultation on building of new facilities by professional safety engineers.
    - Annual safety inspection of facilities by professional safety engineers.

Our recommendations to MCFCS and Ministry of Public Safety and Security (MPSS) for Detention Centers are as follows::

21. Detention Center employees be required to annually review and be tested on Policies and Procedures including management signoff.

22. For intake Procedures:

- The intake worker must be in a position to complete the initial intake before going off shift
- Risk Profile form must be filled out first
- The primary worker be assigned immediately and be working on the present or subsequent shift and be scheduled for two shifts within the next 48 hour period.
- The "factor 9" form should be used for risk assessment
- Intake must be complete with in 48 hours
- There must be follow-up every 12 hours until complete
- The process must be date/time stamped and signed at start of process.
- Medication must be recorded including the primary reason for the medication
- Youth rights must be discussed immediately (RPAC and Child advocacy)
- Institutes Rules and regulations must be reviewed verbally and in writing with the youth

23. Items that must be posted in the intake room include Child Advocacy Office, rights poster ,suicide risk check list and institution rules.

24. A formally structured shift change lead by the shift coordinator must occur with all staff in one room, and include signoff. Information on all new intakes must be reviewed prior to start of each shift. Important information on each resident must be passed on.

25. All written Log book entries must be signed (Initials).

26. Staff meeting minutes published and disseminated to all fulltime and relief workers.

27. Record keeping audited annually by an external agency.

28. A computerized record-keeping and intake system be adopted by all youth corrections facilities. The record-keeping system ought to be capable of date and time stamping all entries and of identifying the individual who has made each entry. Computerized record keeping will ensure that the integrity of the records is maintained.

29. Isolation time (whether secure or non-secure) in any correctional facility to be monitored by staff at all times through either video, audio, or direct surveillance.

30. Facilities submit a standardized written report to the Ministry subsequent to the death of a child residing in the facility.

Reason for above detention centre: To reduce the error and omissions that are significant in the effective operation of a detention centre for young offenders

Police Services.

31. We recommend to MPSS that Police occurrence reports on CPIC relating to suicide attempts must be submitted by the investigating officer before he or she goes off shift.

Reason: To ensure any information about suicide is available for all police as soon as possible.

32. We recommend to MPSS that the police be supplied a list of all youth detention facilities and their categories.

Reason: This will provide a more effective way for police to select detention facility for young offenders.

Coroner's Explanation
of the Verdict of the Jury at the Inquest
into the Death of Paola Rosales - Date of Death July 3, 2001

Dates of Inquest:	September 16, 2002 through October 4, 2002 Holiday Inn - Wyecroft Road, Oakville, Ontario October 21, 2002 through November 1, 2002 Milton Court House - Milton, Ontario
Participants	
Presiding Coroner:	Dr. Christopher Rathwell
Counsel to Coroner:	Ms. Lorna Bolton, Assistant Crown Attorney Municipality of Halton
Investigating Officer:	Detective Constable David Short, Halton Regional Police Service
Coroner's Constable:	Officer William Riddle, Halton Regional Police Service
Court Reporter:	Ms. Lisa Cumber, 29 Flanders Drive, Waterdown, Ontario L0R 2h7 905-541-2742

Parties with Standing	Counsel or Agent
1. Vilma Hernandez, Mother of the deceased	Mr. Erik Lewis
2. Jose Rosales, Father of the deceased	Mr. R. Whitehead
3. Transitions for Youth	Ms. Barbara Walker-Renshaw and Mr. Erik Hoaken
4. Catholic Children's Aid Society of Metropolitan Toronto	Ms. Helen Murphy Chief Counsel to CCAS Ms. Lauren Stringer
5. Peel Regional Police	Mr. William MacKenzie
6. Ministry of Community and Children's Services	Mr. Peter Rusk
7. Physicians involved in the care of Ms. Rosales	Ms. Anne Posno

8. Spectrum Foster Care Services Mr. G.P. Smith

This verdict explanation contains a brief synopsis of the evidence presented at this inquest together with some explanatory remarks about the individual recommendations made by the jury. The sole purpose of this explanation is to assist the reader and to understand the jury's recommendations. It is not intended to replace the verdict. I would like to stress that this explanation is my interpretation of the evidence and the jury's reasons.

Summary Of The Circumstances Of The Death

Paola Rosales, age 14, died at the Hospital for Sick Children in Toronto, Ontario on July 3, 2001 having been pronounced brain dead following a suicide attempt by hanging where she had been incarcerated at a phase one open detention centre in Milton, Ontario. This inquest was mandatory under Section 10 subsections 3 and 4 of the Coroner's Act.

In February of 2001, Paola Rosales made a suicide attempt with a trivial wrist cutting and an Acetamenophen overdose. She was admitted to the Hospital for Sick Children and after being stabilized medically was transferred to the Adolescent Psychiatric Unit where she stayed for approximately two further weeks. During her hospitalization a Toronto Children's Aid Society became involved and following meetings with family, a Temporary Care Agreement was signed and Paola was placed in a foster home setting in Brampton, Ontario. Her file was assigned to a Youth Protection Worker. Over the following weeks and months Paola struggled with depression, issues of abandonment and isolation and an acceleration of acting-out behaviors and suicidal tendencies. Following a minor assault on another child in the foster home, Paola was charged with assault and was immediately re-located to a second foster home model residence in Brampton, Ontario. Paola's behavior and condition continued to deteriorate and she began a pattern of school truancy and acting-out at school and was eventually suspended for the remainder of the school year. On June 25, 2001 Paola ran away from her foster home and missed her court appearance to answer to the assault charge. Paola was located on June 29, 2001 and taken by her Youth Protection Worker to the Police who had no choice but to incarcerate her pending appearance before a judge. She was then placed in a Phase One Open Detention Facility, in Milton, Ontario. She appeared in court on June 30, 2001 and was remanded back to the Phase One Open Detention Facility in Milton, Ontario pending a court appearance at the end of the July 1st long weekend. On July 2, 2001 Paola was sent to her room for misbehavior and while in her room she fashioned a noose from her window curtains and hung herself. She was taken to Milton District Hospital then transferred to The Hospital For Sick Children in Toronto, Ontario and she was pronounced brain dead on July 3, 2001.

The jury heard testimony from thirty-seven (37) witnesses over twenty-five (25) days and reviewed one hundred eighty-nine (189) exhibits.

Testimony was heard from the attending physicians, psychiatrists, psychologists, the youth protection worker and her supervisor, foster parents , Paola's mother, senior administrators and managers involved, agencies and facilities, as well as front line workers.

Throughout witness testimony the issue of effective information gathering, documentation and sharing was prominent. In many situations testimony was given regarding verbal communication of important information i.e. suicide risk, past history of suicidal ideation and ongoing depression and there was little supporting documentation. Very significant information appeared to have not been effectively communicated between care-givers and stake-holders both verbally and in writing.

Expert witnesses included: Dr. Marshall Korenblum, a specialist in adolesencent psychiatry in Toronto. Ms. Sue Stevens from the Ministry of Child and Family Services. Ms. Judy K. Findlay from the Office of the Child's Advocate.

Recommendations

Jury Recommendation #1

We recommend that the Children's Aid Society (CAS) case worker immediately file a form 14 and provide pertinent background information to any medical professional who comes in contact with the child.

We recommend that the College of Physicians and Surgeons direct the medical professional or facility who receives the form 14 to provide the entire record, with an explanation for any excluded portions of the child's record. We recommend that the information from the form 14 be provided within 5 working days.

Reason: Full records often contain important additional information, which may be helpful to subsequent treatment providers. If this information is left out then the diagnosis could be incorrect and inappropriate treatment given.

Coroner's Explanation

The jury heard evidence that a Form 14 was not routinely used in dealing with youth with mental health problems and that information received is often simply summary information.

Jury Recommendation #2

We recommend that the Ministry of Community, Family and Child Services (MCFCS) develop a mandatory one or two page "passport" to be sent immediately for each child in the care of a children's aid society (CAS). No child will be accepted by placement without this passport. It should be sent as well to appropriate medical practitioners.

A secondary detailed package is to follow within two working days.

The immediate passport document shall set out, in concise form, information which is vital to the child's health and safety including information pertaining to the child's past history of suicide attempts;

- current psychiatric diagnoses
- any history of suicide or depression
- any history of violence and/or AWOL behaviors
- a list of the child's medications, dates and refill
- any known medical conditions or allergies
- the names and phone numbers of any health professionals who are currently involved in treating the child
- family contact where no protection issues;

In addition, the passport shall set out the name, phone and fax numbers of the child's assigned worker as well as the phone number for the society's after hours service. The document shall include a list of any family members with whom the child is permitted contact.

The Secondary Package with a complete detailed package of all vital information including the following:

- detailed reason for CAS care
- Form 14
  full doctors report

- complete school records
- complete family medical history

Reason: To assure the ability to care for the safety and security of a child.

Coroner's Explanation

The jury felt that a one or two page simple document could move through the system with a youth indicating significant "need to know" information. A document such as this may well have served to prevent gaps in information that seemed to occur a number of times between various caregivers and agencies during this child's care.

Jury Recommendation #3

We recommend to the MCFCS that the CAS worker assigned to the child is accountable for all flow of information to all caregivers and community services who are in contact with the child while in the care of the CAS. This includes any facility, detention center or jail. It is preferable to use hard copy form as the formal means of communication

Reason: Verbal communication often breaks down.

Coroner's Explanation

The jury heard repeatedly about verbal communications being given but not documented and because of this in many situations, it was impossible to tell where communication fell down. Often these verbal communications were not documented in writing and therefore, did not appear to alert the various care-givers to this child's level of risk.

Jury Recommendation #4

We recommend to the MCFCS that the CAS worker be required to speak frequently enough with a child within the first 72 hours of placement to ensure that their needs are being met and their concerns are addressed.

Reason: The first 48-72 hours is when the child is most at risk.

Coroner's Explanation

The jury heard from an expert witness that the first 48-72 hours are high risk time especially when a child is moving from placement-to-placement including detention.

Jury Recommendation #5

We recommend the MCFCS implement a policy that requires all Children's Aid Society night duty workers to have access to the CAS worker files. All CAS workers

must have an updated passport for each child available to night duty workers.

Reason: Some of the CAS night duty workers do not have access to this information.

Coroner's Explanation

The jury heard evidence that an agency like CCAS might possess fundamentally important information that might be available regarding a child but that on weekends and nights there were difficulties obtaining this information. This recommendation speaks to having information more accessible to all those who might need it including off-hours.

Jury Recommendation #6

We recommend the MCFCS implement a policy requiring the CAS to provide access to legal council for a child whom becomes involved with the Young Offenders Act. This includes attending each and every court appearance. Where there are no protection concerns, parents should be encouraged to attend court to support the youth.

Reason: Children often do not know their legal rights and the children need support.

Coroner's Explanation

The jury heard that Paola never secured legal representation to address her assault charge or her failure to appear charge. The caregivers involved appeared to have a very poor working knowledge of the legal system (young offenders) as it would apply to a child in Paola's situation.

Jury Recommendation #7

We recommend MCFCS implement a policy requiring the initial CAS plan of care meeting to be held within the first week of placement. CAS worker must bring the child's file to all meetings and have foreign language worker present to translate if required. As part of the plan of care, telling the child and parents about child advocates office and an explanation of the residential placement advisory committee process (RPAC) must be done.

All plan of care meetings must result in documented minutes that are signed by all parties. The participants should include: doctors, child, caregivers, home manager and parents where applicable. Assigned tasks must be followed-up on within 24 hours.

Reason: This is necessary to ensure that everyone involved understands the plan and what is expected to happen, especially that the child knows they are cared for and have some control over their life.

Coroner's Explanation

The jury heard evidence that, in spite of concerns about the location of Paola's placement expressed by both Paola and her family, alternatives might have been exercised to address this but workers and family were not aware of these options.

Jury Recommendation #8

We recommend the MCFCS implement a policy requiring all children aid society workers, all foster parents, all staff employed in youth correctional facilities be required to participate in intensive training in the areas of suicide risk identification, assessment and prevention, behavior management, and prevention, Young Offenders Act and Mental Health Act.

Foster parents, correctional staff and CAS workers must be tested regularly as to their knowledge of the indicators associated with heightened risk of suicidality.

MCFCS allocate additional funding without affecting other ministry programs.

Reason: Provide a solid base of important common knowledge for all staff to protect children who enter the child care system.

Coroner's Explanation

This recommendation enforces the idea of providing training for front line workers in assessment and recognition of depression, suicidal ideation and suicide risk. Numerous front line workers testified that they had little or no training around issues of depression and suicide risk assessment, in adolescence and youth.

Jury Recommendation #9

We recommend that the Ministry of Training, Colleges and Universities provide direction to all provincial Community Colleges offering the diploma programs of Child and Youth Worker and Correctional Worker that the curricula of those programs be amended to include substantial course work addressing the identification, assessment, management and prevention of suicidal risk, ideation and behaviors in adolescents, with particular emphasis on the needs and risks of Young People in the Young Offender system; and on the identification and assessment of abnormal adolescent psychology, with emphasis on adolescent depression and the criteria for referral to clinical services.

Reason: In the course of their employment, these workers encounter increased numbers of youths who are at risk of suicidal behavior, and the curriculum should reflect the changes in our society.

Coroner's Explanation

The court heard evidence that colleges and universities who train youth workers appear to have a dearth of material in their curriculum regarding mental health issues for adolescences and youth.

Jury Recommendation #10

We recommend the federal and provincial Ministries of Health allocate additional resources for:

- The establishment of both inpatient and community-based psychiatric programs for youths.
- The number of applicants for psychiatric residency programs doubles the number of positions available. We recommend additional funding to hospitals and universities so as to permit a greater number of adolescent psychiatrists to be trained and qualified in the province.
- In the case of children in the care of a children's aid society, we recommend the compensation child psychiatrists for their attendance at case plan or case conference meetings.

Reason: In the Mental Health system at present, there is a dearth of both inpatient and outpatient psychiatric services for adolescents in this province. IF adolescent suicide is to be prevented, it is imperative this deficiency be rectified as soon as possible.

Coroner's Explanation

The jury heard from a number of physicians that child psychiatry residency programs are scarce and child psychiatrists available in many communities are minimal. These recommendations are suggested to enhance physician resources for children's mental health issues especially child and adolescence psychiatrists.

Jury Recommendation #11

We recommend the MCFCS, in conjunction with the provinces' children's aid societies, develop strategies for recruiting foster parents, particularly in the GTA. We recommend a study of the per diem rates as an incentive to recruit more foster care homes.

Reason: There is a dearth of suitable foster homes in the province, particularly in the Greater Toronto Area. As a result, children are often placed in foster homes far from their families and friends, this is an important factor in the mental health of a child.

Coroner's Explanation

The jury heard that foster home resources are rather limited and that the more urban centres have difficulty attracting foster care parents due in part to cost of living issues.

Jury Recommendation #12

We recommend the MCFCS adopt a standardized contract which clearly outlines each parties responsibilities to be used between all CAS agencies and residential placement. The contract must be signed before any children are placed with that facility.

Reason: This will provide an efficient mechanism to define responsibilities and expectations of the out placement facilities.

Coroner's Explanation

The jury heard that a service contract was signed with the second foster care service but this was done after the death of Paola Rosales. Several witnesses appeared to demonstrate some confusion regarding their exact responsibilities and expectations regarding the roles and responsibilities of various parties involved in the care and support of this child.

Jury Recommendation #13

We recommend MCFCS provide a secure web site that contains the detailed status of the licenses of all residential foster and group homes and any "serious occurrence" reports for all CAS agencies to access.

Reason: The current ministry information is not readily accessible to the CAS to make appropriate judgments about placements.

Coroner's Explanation

The importance of readily accessible vital information regarding a child in care and at risk was reviewed several times. This is one of the jury's ideas aimed at enhancing availability of information and access to information regarding a child in care.

Jury Recommendation #14

We recommend that the Ministry of Health prepare amendments to the Mental Health Act to have separate criteria for involuntary admittance of adolescents vs adults.

Reason: The characteristics or adolescent mental problems differ significantly from those of adults.

Coroner's Explanation

The jury appeared to be of the opinion that the criteria for involuntary admission to some extent, prevented caregivers from getting Paola psychiatric treatment that may have been helpful.

Jury Recommendation #15

We recommend to the Ministry of Corrections that suicidal tenancies should be a separate criteria for a provincial director to level determine an adolescent for a secure facility with clinicians on staff if applicable to that youth.

Reason: It has become apparent that there is inadequate ability to keep safe the youth in open detention facilities.

Coroner's Explanation

The jury heard that criteria for level determination for placement facilities are rather rigid and might not have been applied effectively in Paola's case, ie she might have been better placed in a secure facility with psychiatric support rather than a phase one detention facility. The jury heard that there was a lack of communication of serious occurrences in Paola's case on more than one occasion and that this information again, may have alerted the youth protection worker and others to her serious deteriorating condition.

Jury Recommendation #16

We recommend the MCFCS and the Ministry of Corrections put a policy in place that all incident reports be faxed immediately (within 24 hours) upon completion to the CAS worker for any children in care.

Reason: This is required for the flow of information to support the CAS program.

Coroner's Explanation

We heard in evidence that there was a lack of communication of serious occurrences in Paola's case on more than one occasion and this information again, may have alerted caregivers to Paola's deteriorating condition.

Jury Recommendation #17

We recommend the Ministry of Health catchments area policy have a clause allowing access to a previous mental health medical professional if deemed necessary.

Reason: Promotes consistency and stability for the child in dealing with mental health professionals.

Coroner's Explanation

The jury heard that many of the treating health professionals were unaware of, and did not communicate, with other simultaneously treating health professionals. The jury felt that these gaps in communication should be reduced as much as possible.

Jury Recommendation #18

We recommend the Ontario Association of Children Aid Societies publish jury recommendations and disseminate to facilities and agencies.

Coroner's Explanation

The jury recognizes the importance of disseminating information regarding these serious matters to all youth workers and youth service agencies.

Jury Recommendation #19

We recommend the Ministry of Health stipulate that no medical facility can deny or refuse treatment to youth in a young offender facility. We also recommend that MCFCS and Ministry of Public Safety and security (MPSS) provide funding for open detention and open custody facilities for young persons in order to secure clinical support for young persons suffering from depression and suicidal ideation.

Reason: It was noted that these facilities have a great difficulty providing these services for young persons.

Coroner's Explanation

The jury heard that there was minimal mental health support in correction and detention type facilities and that Paola might not have fit the criteria for transfer admission to a more secure facility with better mental health resource. The jury heard that there was little funding and in fact, cut-backs regarding prevention and early mental health intervention in the young offenders system.

Jury Recommendation #20

MCFCS and MPSS should create an independent, autonomous regulatory body as an external quality assurance mechanism responsible for:

- the licensing of facilities
- the ongoing development and revision of service delivery standards and best practices focused on client outcomes and results
- providing direction to individual facilities on policies and procedures that me be required to meet provincial standards
- accountability for the investigation of serious occurrences and, where appropriate, the development of strategies and action plans for corrective action
- setting standards for staff qualifications and training expectations
- guideline for acceptance forms of windows coverings
- mandatory safety inspection and consultation on building of new facilities by professional safety engineers
- annual safety inspection of facilities by professional safety engineers

Coroner's Explanation

The jury felt that an independent review and regulatory body could enhance quality assurance in the various facilities and care provision agencies involved in youth care. The jury heard that the Ministry licensing process has an enormous case load expectation and that licensing inspections are geared toward assuring only that minimum standards are being met. The jury felt that this level of surveillance should be enhanced.

Jury Recommendation #21

Detention Center employees be required to annually review and be tested on Policies and Procedures including management signoff.

Coroner's Explanation

The jury heard that most of the workers at the detention facility had very little knowledge of the policies and procedures and there was no mechanism to ensure that these were reviewed and understood by staff.

Jury Recommendation #22

For intake procedures:

- the intake worker must be in a position to complete the initial intake before going off shift.
- risk profile form must be filled out first
- the primary worker be assigned immediately and be working on the present or subsequent shift and be scheduled for two shifts within the next 48 hour period.
- the "factor 9" form should be used for risk assessment.
- intake must be complete within 48 hours.
- there must be follow-up every 12 hours until complete.
- the process must be date/time stamped and signed at start of process.
- medication must be recorded including the primary reason for the medication.
- youth rights must be discussed immediately (RPAC and Child Advocacy).
- institutes rules and regulations must be reviewed verbally and in writing with the youth.

Coroner's Explanation

The jury heard that the intake procedure for the detention facility, if carried out correctly, should have identified Paola Rosales at extremely high risk for suicide and modified their program and surveillance level. However, the evidence demonstrated that this intake procedure and documentation was never completed during the four days of her incarceration. Significant information was obtained but never effectively disseminated. These duties seem to have been passed on from shift-to-shift without any clear delegation of responsibilities to ensure that the intake information was collated and reviewed and acted upon.

Jury Recommendation #23

Items that must be posted in the intake room include Child Advocacy Office , rights poster , suicide risk check list and institution rules.

Coroner's Explanation

The jury did hear that posters regarding children's rights, suicide risk check list and institution rules are posted and visible at the phase one open detention facility in Milton but it was not clear that these documents and rights informations are posted in other children's residential facilities.

Jury Recommendation #24

A formally structured shift change lead by the shift coordinator must occur with all staff in one room, and include signoff. Information on all new intakes must be reviewed prior to start of each shift. Important information on each resident must be passed on.

Coroner's Explanation

This recommendation speaks to enhancing information flow both verbal and written, in facilities that care for youth and youth who may be at high risk. The jury felt that a more formalized verbal hand-over with a clearly responsible leader would enhance the completion and dissemination of important information.

Jury Recommendation #25

All written log book entries must be signed (initials).

Coroner's Explanation

The log book at the phase one open detention facility had a number of entries which were not signed or initialed and therefore, it became difficult at times to ascertain staff's activities, statements, and actions.

Jury Recommendation #26

Staff meeting minutes published and disseminated to all fulltime and relief workers.

Coroner's Explanation

This recommendation attempts to enhance communication to all staff involved in a child's care of important, pertinent and new information.

Jury Recommendation #27

Record keeping audited annually by an external agency.

Coroner's Explanation

This recommendation speaks to an attempt to enhance accountability and thoroughness in the written documentation and documents that should augment a child's care and safety while in the care of this type of facility.

Jury Recommendation #28

A computerized record-keeping and intake system be adopted by all youth corrections facilities. The record-keeping system ought to be capable of date and time stamping all entries and of identifying the individual who has made each entry. Computerized record keeping will ensure that the integrity of the records is maintained

Coroner's Explanation

The jury heard that the MacMillan Youth Centre is moving towards an enhanced computerized record keeping system. It was felt that proceeding with this would benefit all youth in the facility and enhance checks and balances to ensure that as much information as possible is recorded and disseminated in a timely fashion.

Jury Recommendation #29

Isolation time (whether secure or non-secure) in any correctional facility to be monitored by staff at all times through either video, audio, or direct surveillance.

Coroner's Explanation

The jury heard a review of the facilities policies and procedures regarding isolation time. This did not appear to be followed very carefully nor was there documentation to support staff's statements regarding their actions and decisions. It was the jury's feeling that a child at high risk should not be isolated without direct observation.

Jury Recommendation #30

Facilities submit a standardized written report to the Ministry subsequent to the death of a child residing in the facility.

Reason for the above detention centre: to reduce the error and omissions that are significant in the effective operation of a detention centre for young offenders.

Coroner's Explanation

The phase one open detention facility management conducted a review after the death but there was no standardized protocol to follow.

Jury Recommendation #31

We recommend to the MPSS that police occurrence reports on CPIC relating to suicide attempts must be submitted by the investigating officer before he or she goes off shift.

Reason: To ensure any information about suicide is available for all police as soon as possible.

Coroner's Explanation

This child's earlier (February 2001) suicide attempt did appear on the CPIC system and was posted in a timely fashion however, a subsequent suicide attempt was only logged on the system approximately two months following Paola's death. It was felt that this information could be very significant if a youth is involved in the Young Offender's System and has mental health issues.

Jury Recommendation #32

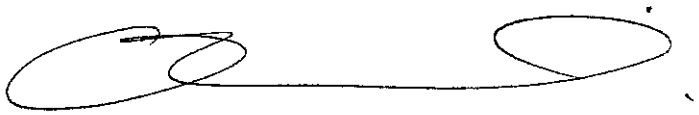
We recommend to MPSS that the police be supplied a list of all youth detention facilities and their categories.

Reason: This will provide a more effective way for police to select detention facility for young offenders.

Coroner's Explanation

The court heard in evidence that youth detention facilities levels of service criteria for admission, staff support and catchment areas was not entirely clear to police services involved in this child's care.

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's verdict. It is worth repeating that it is <u>not</u> 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 or a conclusion of the Jury it would be greatly appreciated if it could be brought to my attention and I will obviously gladly correct the error.



C. K. Rathwell, B. A. M.D., C.C.F.P.
Presiding Coroner