Expert Panel Review of Deaths of Children and Youth in Residential Placements

Terms of Reference
November 2017

PURPOSE

The Office of the Chief Coroner (OCC) has identified a group of 11 deaths of young people in the care of a children's aid society that occurred while they were in residential placements between January 1, 2014 and July 31, 2017. All 11 young people had a history of mental health challenges.

The OCC is establishing an expert panel to inform the investigation of the deaths of these 11 young people and inform potential recommendations to help prevent further deaths. With these overarching objectives in mind, the expert panel will:

1. Review and assess the services and supports provided to the 11 young people;
2. Identify any commonalities and/or trends arising out of the review and assessment of the deaths;
3. Identify any systemic issues or concerns arising out of the review and assessment of the deaths;
4. Provide expert opinion on the extent to which current and forthcoming plans, activities, legislation, regulations, policies and practices, including the activities outlined in Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services and activities underway in the child welfare and children's mental health sectors address any issues or concerns identified;
5. Make recommendations to the Chief Coroner, if appropriate, with a view to effective intervention and prevention strategies, toward the prevention of further deaths.

A report offering a summary of the 11 deaths, the panel's work and any recommendations made by the OCC will be made available to the public.

BACKGROUND

This review will examine a cohort of 11 deaths of young people that occurred while they were in a residential placement. These settings were characterized by reporting children's aid societies in various ways, including group homes, foster homes, treatment homes and agency operated group homes.

All 11 young people had a history of mental health challenges, and seven of the young people died by suicide. One young person was the victim of a homicide. The remaining three young people died of undetermined causes. A death is classified as undetermined when a full investigation has shown no evidence for any specific classification or there is equal evidence or a significant contest among two or more manners of death.

Of the 11 young people that died, seven were Indigenous. The Indigenous young people who died were predominantly in placements outside of their home communities.

A number of potential common issues were identified during a preliminary review of the 11 cases, including (but not limited to):

- Method of and rationale for placement selection for the young people, including limited understanding of whether the young people's needs drove placement decisions;
- The availability of placements with ability to meet the needs of young people with mental health challenges;
- The number of placement changes that young people experience;
- In the far North, the availability of placements in a child's home community, or close to their home community;
- The training and qualifications of caregivers to address the needs of young people with mental health challenges;
- The differing requirements related to oversight and other aspects of care for residential placement types, and the potential implications of reduced requirements in foster care settings;
- The availability of therapeutic treatment resources for these young people, either within the placement or outside of it;
- The oversight required and exercised by children's aid societies while young people are placed; and
- The oversight of residential placements by the Ministry of Children and Youth Services (MCYS).

These issues are recognized by those involved with care in residential placements, including MCYS. In 2015, MCYS did its regular five year review of the *Child and Family Services Act*. The review identified concerns across a number of areas, including:

- Human resources;
- Variability in quality and safety across residential placements;
- Lack of robust standards and regulations to ensure the safety of young people;
- Settings not reflective of cultural and linguistic realities of all Ontario's young people;

In February 2016, a Residential Services Review Panel appointed by MCYS presented their report, *Because Young People Matter*, *Report of the Residential Services Review Panel,* to MCYS. The report made 33 recommendations. Several of the recommendations are intended to address some of the issues identified during the preliminary review of these 11 deaths.

Most recently, MCYS released Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services aimed at improving the care, safety and oversight of residential care. There is also work underway by the Ontario Association of Children's Aid Societies, the Association of Native Child and Family Service Agencies of Ontario and Children's Mental Health Ontario, to identify, develop and help implement solutions to address current critical issues in residential services[1].

SCOPE OF REVIEW

The purpose of the expert panel review is to inform the OCC in its investigation of the deaths of these young people and to identify potential recommendations to the Chief Coroner which, if implemented, may help prevent further deaths.

The review is intended to be specific to the services and supports provided to the 11 young people that are linked by the fact that their deaths occurred in residential placements.

With respect to the residential placements in which the young people were living, the expert panel may also review or discuss the suitability of the placement, availability of services, and issues of service quality and oversight mechanisms.

The reviewers may contemplate the ways in which determinants of health, socio-economic circumstances and the intersections between systems of care may have impacted the outcomes of these young people.

Services and service systems that were not directly linked with those provided to the 11 young people are out of scope and beyond the mandate of the Office of the Chief Coroner.

Recommendations may be specific to service providers that provided services directly to the 11 young people, and/or may address findings related to systemic issues.

The review is intended to provide supplementary information to the Chief Coroner for his consideration and may or may not be accepted.

[1] Many organizations use the language "residential services". We have used residential placements to refer broadly to the settings in which these young people were living. It is not clear at this time whether the work underway encompasses all residential placement settings that are relevant to this review.

LEGISLATIVE MANDATE

The report is to be developed pursuant to section 15(4) of the *Coroners Act,* R.S.O. 1990, c. 37, on the basis that it is to be used for the sole purpose of a coroner's investigation, and not for any litigation or other proceedings unrelated to the coroner's investigation. Moreover, the opinions expressed by the panel will be limited to the information provided and considered for the purposes of the report.

COMPOSITION OF PANEL

The panel will be composed of a number of individuals not to exceed seven, and will include individuals with experience in the following areas:

- psychiatric and/or psychological care of young people
- community mental health care
- services to Indigenous young people
- residential placements in Ontario
- the service system, including child welfare, child and youth mental health and youth justice systems
- government administration

The panel is not intended to be representative of Ontario's population or any subgroup, or the service system. Rather, areas of expertise have been identified with a view to best enabling the achievement of the objectives outlined in the PURPOSE section of this document.

INFORMATION AVAILABLE

Materials relevant to the services and supports provided to the 11 young people and the circumstances of their deaths will be provided to the expert panel. This may include the records of various service organizations.

In addition, the input of family and community members (where relevant) will be sought by staff of the OCC and provided to the panel for its consideration.

Additional materials may be requested to help clarify any current and forthcoming policies and practices that the panel deems relevant. The panel may elect to interview specific parties, such as representatives of MCYS or the members of the Residential Services Review Panel for this purpose.

The panel will not interview service providers, family members, caregivers or others involved in the direct provision of services and supports to the 11 young people, however; if specific questions arise then the information may be sought by a person designated by the OCC.

AMENDMENTS TO TERMS OF REFERENCE

The terms of reference can be amended by the authority of the Chief Coroner for Ontario.

Recommendations for amendments may come from the panel.

ACCESS TO REPORTS/INFORMATION

A report offering a summary of the 11 deaths, the panel's work and any recommendations made by the Chief Coroner for Ontario will be made available to the public.

Access to any other information or reports will be governed by the provisions of the *Coroners Act* and the *Freedom of Information and Protection of Privacy Act*.