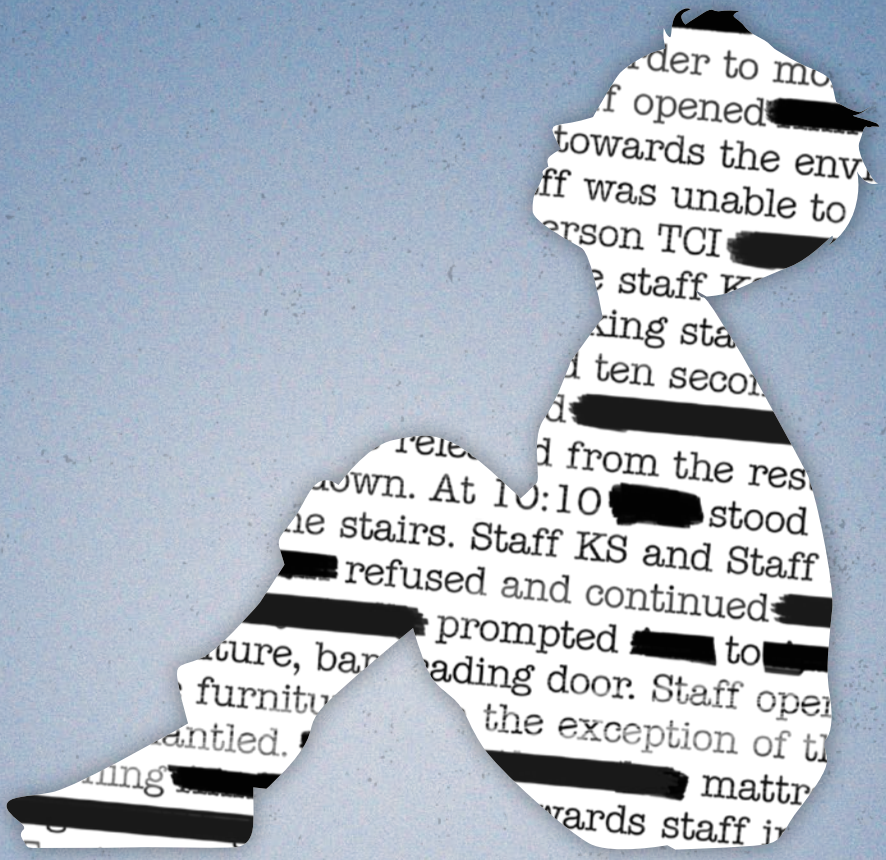
Provincial Advocate
for Children & Youth



IN HARM'S WAY?

SERIOUS OCCURRENCES REPORT VOL. 2

Office of the Provincial Advocate for Children and Youth

SERIOUS OCCURRENCES REPORT

FOLLOW UP TO SOR PRELIMINARY REPORT NOVEMBER 2017

Office of the Provincial Advocate
for Children and Youth

Dr. Kim Snow, Ryerson University

Provincial Advocate for Children & Youth

Serious Occurrences Report Volume 2
Office of the Provincial Advocate for Children and Youth, and Dr. Kim Snow

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A MESSAGE FROM THE PROVINCIAL ADVOCATE

In recent months, the government has committed to a blueprint to fundamentally change residential care in Ontario. Influenced by a youth panel supported by the Office of the Provincial Advocate, a blueprint was developed that set forth a plan to build a child-centred system. In addition, the government, confronting tragedy in residential care, has taken the advice of the Advocate's Office and begun to analyze and act upon Serious Occurrence Reports. In the meantime, calls to the Advocate's Office from children in these homes continue unabated.

Young people, particularly but not exclusively those living in group homes, have told us that they feel alone and isolated. They feel "invisible."

Serious Occurrence Reports are meant to be a way for the government, which is ultimately responsible for the care of these children, to know when something goes wrong. Each year, the Ministry of Children and Youth Services receives over 20,000 Serious Occurrence Reports. Presumably, when Serious Occurrence Reports were instituted, someone believed that they would be read. Someone would have thought that they would be used as an early warning sign of something going wrong at a residence — or in a child's life — and used as a tool to provide oversight by our government, on behalf of all of us.

This report provides service providers, the government and the general public a peek into the serious situations that occur at some residential programs. The numbers detail incidents that are likely troubling to the children living in these programs, as it would be for the adults that care for them. Imagine what it is like for the children living in the residences most frequently using physical restraints or those programs that report children frequently missing. As people begin to look more carefully at the reports, they should see a child. In the same way that a parent would ask their child "What happened?" after receiving a call from a principal, those responsible for the placement should make sure that the young person's version of the serious occurrence is known. What can we learn from them and this report to better serve those children and support these residences? How can we come together to use this information to set indicators that allow for review, provide enhanced supports or creative solutions to reduce the number of incidents, prevent children from going missing, and limit the use of physical restraint? Collectively, we need to consider what we should do to reduce the chances of medication errors and increase the physical and emotional safety of the children in residential care.

The SORs were meant to be read and this report provides a deep analysis of these reports. We have been given a window into the serious situations that can occur in a residence and now that the lens exists, we must continue to look in on the children and youth in care to make certain that every safeguard available to the government is used to ensure that they are not in harm's way.

Irwin Elman

PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH

INTRODUCTION

> *After Joe completed his homework, he began to demand his system and dictate program to staff member Smith. The writer heard Joe's elevated voice from across the house and went to see what was happening. Joe was being rude and non-compliant with staff member Smith, in close proximity to peers. Joe was asked by staff member Smith to follow program expectations. Joe appeared to calm and comply with the request, so the writer left the area to go back to the office. Once in the office the writer again heard Joe's elevated voice. The writer again went to assist. Joe was not where staff member Smith had told him to be. The writer questioned Joe on this and Joe responded rudely to the writer. Staff member Smith and the writer then briefly redirected Joe away from his peers. Staff member Smith controlled the left arm and the writer controlled the right. Joe began to struggle and threaten harm to staff. Joe was briefly placed in a standing position of control, but was able to free his left arm and swing at the writer. After a brief struggle, the writer placed Joe in a prone position of control and staff member Jones was able to attain control of Joe's left arm. Joe was held for approximately ten minutes in this position at which point he was able to be released. Joe has continued to refuse to debrief with staff regarding this incident.*

The situation involving Joe is copied from a real report (known as a *Serious Occurrence Report* and referred to in this report as a SOR) written by a staff member at a group home and submitted to the Ontario government. Although the names of the individuals were changed, nothing else from the staff member's description of the event has been altered. Submitted as a final report and signed-off by a supervisor as complete, the report still leaves the reader with many questions. For instance, Joe is described as being *"rude"* and *"non-compliant,"* but no examples are given of what he has said or done to justify these characterizations. Even if we accept that he was being rude and non-compliant, there is no indication that the staff member or others were at any risk of harm — which is the legal criteria for using physical restraint — or what it was that prompted the staff member to physically intervene to "control" Joe's arms. According to the report, Joe only *"swing[s] at"* the staff member after he is physically grabbed by them. Is it possible that Joe's reaction was one of defending himself or even just a natural reaction to being grabbed? What redress is there for Joe if he feels that he was the one to be assaulted in this situation? One might also question how often physical restraints are used in this home, how many of the reports filed by this service provider lack the information required to justify the use of a physical restraint, and whether it is common or uncommon for this agency to provide reports where the perspective of the young person is missing.

These are the kinds of questions that should be considered by anyone with oversight responsibility for the care of young people in children's residences. After all, *Serious Occurrence Reports* represent an official notification about the kind of incidents deemed significant enough to be reported directly to the Ontario government and often reflect the types of situations young people have been raising concerns about for decades.[1]

This report describes the findings of an analysis conducted by the Office of the Provincial Advocate for Children and Youth ("Advocate's Office") of 4,436 SORs filed with the Ministry of Children and Youth Services (MCYS) during a three-month period in 2014. Examples of some of the patterns detected as a result of this analysis include the following:

- 25 agencies are responsible for 80% of the SORs filed about physical restraints
- 27% of SORs relate to young persons with disabilities
- 36% of SORs involve contact with police
- 40% of SORs reported under the category of serious injury relate to self-inflicted injury
- The perspective of the young person is blank in 59% of the reports in which it is specifically required
- Information to justify the use of a physical restraint was absent in 44% of SORs reviewed

For those who have legal duties and obligations toward these children, including the Ministry of Child and Youth Services (MCYS), individuals placing children in residential care, placing agencies such as children's aid societies or other service providers, and the staff and management of the home where the incident has taken place, SORs can and should be regarded as significant sources of information that must be reviewed, analyzed, and acted upon.

1 Raychaba, B (1993). *Pain lots of Pain: Family violence and abuse in the lives of young people in care.* Ottawa: National Youth in Care Network; Kendrick & Steckley (2008). "Physical restraint in residential Childcare: The experiences of young people and residential workers." *Childhood*, 15 (4), 552-569.

1. ABOUT THIS REPORT

This is the second of two reports by the Advocate's Office about Serious Occurrences Reports (SORs) in children's residences.

The purpose of this report is two-fold: (1) to analyze the serious incidents reported to the government between January 1, 2014 and March 31, 2014; and (2) to demonstrate that the routine and systematic review of these reports has the potential to serve as a safeguard for vulnerable children.

The first section of the report tabulates how often each type of serious event or occurrence was reported and assesses compliance with the rules of reporting, as set out in Regulation 70[2] of the *Child and Family Services Act* (CFSA). While the initial report (*Serious Occurrences Report: Preliminary Report 2016*) provided a first-pass accounting of the data and high-level reporting of the number of reports submitted, this second report provides detailed and descriptive reporting of the full analysis of the SORs and includes discussion about the implications of these findings. This second report also includes more detailed analyses of physical restraint, instances of self-harming, police involvement at residential facilities, missing children, and children placed at great distance from their home community or from another province. Finally, the findings of a simple sorting method of analysis are demonstrated to show how SORs can be used to identify "red flags," trends, and patterns.

WHAT IS A SERIOUS OCCURRENCE REPORT (SOR)?

Some children live away from their family in children's residences. A young person may reside in a children's residence to receive residential care as part of a children's aid society placement, for mental health care, or due to the young person's complex needs. In Ontario, children's residences are either government run, or operated by non-profit and for-profit service providers. Ontario reports a total of 16,037 licensed children's residential beds as of March 31, 2014. For the purpose of clarity, it is important to recognize that this number reflects the number of available beds and not the number of children residing in these programs on any given day. In addition, there is an unknown, but much smaller, number of non-licensed children's residences for fewer than three children. MCYS reports that it does not track non-licensed residential programs, except for the monitoring of eight of the 176 clients with complex special needs (CSN).[3]

Under Regulation 70 of the *Child and Family Services Act*, a licensed children's residence is required to notify, within 24 hours, the Ministry of Children and Youth Services, as well as a parent and those responsible for the placement of a child in the residence, if one of eight designated types of incidents has occurred.[4] These are:

- Death of a client
- Serious injury to a client
- A resident is injured by a staff person or by the licensee
- A resident is abused or mistreated
- Physical restraint of resident by staff
- Complaint made by or about a client that is considered to be serious in nature
- Fire or other disaster on the premises
- Any other serious occurrence
- A resident is absent from the residence without permission for 24 hours or more/ a resident is absent without permission for less than 24 hours, but the absence is considered to be a serious matter

MCYS, in conjunction with the Ministry of Community and Social Services (MCSS), have issued reporting guidelines for SORs and "enhanced" SORs that service providers are expected to follow. These reporting guidelines include, among other things, an overview of the process including information about each type of serious occurrence as it is defined by the Ministry, a glossary of terms, and a summary of the specific responsibilities of service providers.[5]

SORs are intended to provide a timely recounting of events and are a source of information for people responsible for ensuring the care and safety of children in care. In the view of the review team, a fully completed report provides an account of the service provider's impression of what happened, who was involved and what was done, and, in the case of physical restraint, the debriefing of the child.

2 RRO 1990, Reg 70, s 102.

3 Parker, C. (2016b). Request PACY2016-0010. Business Planning and Corporate Services Division. Ministry of Community and Social Services, Ministry of Children and Youth Services. March 31.

4 RRO 1990, Reg 70, s. 102.

5 Ministry of Community and Social Services/Ministry of Children and Youth Services (2013). *Serious and Enhanced Serious Occurrence Reporting Guidelines*.

As a result, the content of these reports should be of utmost importance to the government, children's aid societies, placing agents, and residential service providers because they can identify trends and patterns, provide assurance that a particular incident was dealt with appropriately, or convey early warning of potential problems.

WHY LOOK AT SERIOUS OCCURRENCE REPORTS?

In most cases, the reader of an SOR is provided with a description of a particular incident through the lens of the service provider writing the report. It is frequently not a complete picture, because many times the perspective of the young person who is the subject of the SOR is not included. Even so, SORs represent an 'official account' of some things that young people have been raising concerns about for decades.

In 2011, a team of young people and dozens of youth volunteers worked with the Advocate's Office to hold hearings designed to address the issues faced by many children and youth who are/ were in care, as they age out of care and after they leave care in Ontario. Their report *(My Real Life Book)*[6] and the subsequent *Final Report of the Youth Leaving Care Working Group,*[7] raised a number of concerns about the vulnerability, isolation, safety, and well-being of young people in residential care, as well as the potential criminalization of youth who may be struggling while living in these circumstances. Young people themselves called for a vision of "care" in which they would be "safe, protected and respected" from "the moment we begin our journey … to the moment we leave."[8]

This call from young people was not the first time that the province has heard about the need for safeguards for children receiving residential care and treatment. In December 1990, the Ontario Government released a report entitled "*Review of Safeguards in Children's Residential Programs.*"[9] This review was prompted in part by the emergence of allegations of abuse in government-funded residential and training schools. In 1998, Ontario's Office of Child and Family Service Advocacy released a report entitled "*Voices From Within: Youth in Care in Ontario Speak Out.*"[10] Concerns about the use of intrusive measures (such as physical restraints and the use of isolation) that arose from that youth consultation prompted the government to establish the *Intersectoral/Interministerial Steering Committee on Behavioural Management Interventions for Children and Youth in Residential and Hospital Settings*. This committee released the results of their deliberations on March 31, 2001.

Another report was created in 2016 by young people working as Youth Amplifiers at the Office of the Provincial Advocate for Children and Youth. They travelled across Ontario and met with young people in various residential settings to hear about their experiences in care. This report, *Searching for Home*, contained commentary about the use of physical restraints, which were described by some young people as arbitrary, punitive, and violent.[11] The report also raised concern about the frequency of calls to the police by residential staff, and noted that young people who did not feel safe often did not report their concerns because they had no idea how to do so. It was specifically recommended that residential staff be trained in "de-escalation and prevention strategies to help children and youth manage their behaviour" and that police "only be contacted as a last resort."[12] One of the recurring themes in the many recommendations from this report was that the perspectives of young people should be integrated into all aspects of residential care and taken much more seriously by those responsible for exercising oversight over this system.

Under the *Child and Family Services Act*,[13] young people can only be placed in residential placements that comply with the Act and its accompanying regulations. This obligation extends both to those who operate children's residences[14] and to placing agencies such as children's aid societies.[15] Some of the rules imposed by this legal framework include prohibitions against: corporal punishment;[16] the use of harsh or degrading measures to humiliate a

6 Office of the Provincial Advocate for Children and Youth (2012). *My Real Life Book. Our Voice Our Turn: Youth Leaving Care Hearings.*

7 Youth Leaving Care Working Group (2013) *Blueprint for Fundamental Change to Ontario's Child Welfare System: Final Report of the Youth Leaving Care Working Group* (Toronto: Ministry of Children and Youth Services).

8 PACY (2012). *My Real Life Book. Our Voice Our Turn: Youth Leaving Care Hearings.* p.30-31.

9 Campbell, J. (1990) *Review of Safeguards in Children's Residential Programs: A report to the Ministers of Community and Social Services and Correctional Services*.

10 Snow, K. & Finlay, J. (1998). *Voices from Within: Youth in care in Ontario Speak Out.* Queen's Printer for Ontario.

11 Provincial Advocate for Children and Youth (2016). *Searching for Home: Reimagining Residential Care,* Office of the Provincial Advocate for Children and Youth (Toronto) p.37.

12 Provincial Advocate for Children and Youth (2016). *Searching for Home: Reimagining Residential Care*, Office of the Provincial Advocate for Children and Youth (Toronto) p.50.

13 *Child and Family Services Act*, RSO 1990 c. C. 11.

14 *Child and Family Services Act*, RSO 1990 c. C. 11 s. 193 (8).

15 *Child and Family Services Act*, RSO 1990 c. C. 11 s. 14.

16 *Child and Family Services Act*, RSO 1990 c. C. 11 s. 101.

resident or undermine a resident's self-respect;[17] and the deprivation of basic needs, such as food, shelter, clothing and bedding.[18] It also requires licensees to make reasonable provisions for the care, safety and supervision of young people[19] and stipulates that physical restraints are only to be carried out in accordance with rules outlined in Regulation 70 and cannot be used for the purpose of punishment.[20] Furthermore, residential care operators are required to ensure that their staff are not only aware of the specific agency's policies about the use of physical restraints, but also the legal and MCYS government policies relating to the use of physical restraints.[21]

What is also clear under the law is that when a young person is a permanent Crown Ward, the government has the rights and responsibilities of a parent for the "care, custody, and control" of that young person.[22] These powers are exercised and performed by the society caring for the child. In the case of temporary society wards, individual children's aid societies have the rights and responsibilities of a parent.[23] In addition, government employees known as Program Supervisors have extensive powers under the CFSA in order to ensure compliance with the legislation and the regulations.[24] (Similar obligations are outlined in the *Child, Youth and Family Services Act, 2017*, which has received Royal Assent, but is not yet proclaimed in force).

Although SORs often contain an incomplete account of events, they are the version of events provided to those who are tasked with ensuring that young people in care are safe. As described above, this includes the placing agency, the residential service provider, and the government.

Through undertaking thorough descriptive analysis of SORs filed during a specified time period, the Provincial Advocate hoped to be able to determine whether a rigorous review of these reports — which often speak to the types of incidents that are of significant concern to young people — could act as an early warning system and potential safeguard, both for children and youth, and those with responsibilities towards them. This report, and the data upon which it relies, confirms that this is the case.

17 RRO 1990 Reg. 70, s 96 (a).
18 RRO 1990 Reg. 70 s 96 (b).
19 RRO 1990 Reg. 70 s 104 (4).
20 RRO 1990 Reg. 70 s 109.1
21 RRO 1990 Reg. 70 s 109 .3 (2).
22 *Child and Family Services Act*, RSO 1990 c. C. 11 s. 63.(1).
23 *Child and Family Services Act*, RSO 1990 c. C. 11 s 63.(2).
24 *Child and Family Services Act*, RSO 1990 c. C. 11 s 6.(1).

OFFICE OF THE PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH

The Advocate's Office provides an independent voice for Ontario's children and youth who are either "in care" or on the margins of government care. Reporting directly to the Legislature, the Advocate's Office partners with children and youth, including those who are First Nations and those with special needs, to elevate their voices and to prompt action on their issues.

The Advocate's Office derives authority from the *Provincial Advocate for Children and Youth Act, 2007*.[25] In response to a request, complaint, or on its own initiative, the Advocate's Office acts on behalf of concerns of individuals or groups of children and youth. It can undertake reviews, make recommendations, and provide advice to governments, facilities, agencies, or service providers. The scope of its authority to conduct reviews includes the power to review facilities, systems, agencies, service providers, and processes. The Advocate's Office also has the power to conduct investigations into services provided by a children's aid society or a residential licensee where a children's aid society is the placing agency. In interpreting his powers, the Provincial Advocate is required by statute to apply the principles of the *United Nations Convention on the Rights of the Child. (s.2(3))*.

This report constitutes a review under s 16 (1) (p) of the *Provincial Advocate for Children and Youth Act, 2007*.

The approach to the discussion and analysis contained in this report rests on five main criteria: (1) the obligations placed on service providers through law, policy or ministry directives; (2) Article 19 of the *United Nations Convention on the Rights of the Child* (UNCRC) which requires governments to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, while in the care of a parent, legal guardian or any other person who has care of the child;[26] and (3) the right of a young person, under Article 12 of the *United Nations Convention on the Rights of the Child*, to express their views freely in all matters that affect them;[27] (4) the rights of young people set out in provincial legislation such as the *Child and Family Services Act*, and the *Child, Youth and Family Services Act, 2017*; and (5) the right of all Canadians (including children in care) as guaranteed under section 7 of the *Canadian Charter of Rights and Freedoms*, to security of the person and the right not to be deprived thereof, "except in accordance with the principles of fundamental justice."[28]

25 *Provincial Advocate for Children and Youth Act, 2007,* SO 2007, c.9.
26 UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577.
27 UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577.

It is noted that while the *Child and Family Services Act* contains a provision that children in care have a right to be consulted and to express their own views when significant decisions are made about them[29], the not-yet-but-soon-to-be proclaimed *Child, Youth and Family Services Act (CYFSA), 2017* (not yet proclaimed in force); expands the right to be consulted and to express their own views to include all children and youth receiving services under the CYFSA (not just children in care) about any matter that affects them (not just when decisions are made about them), and to "raise concerns or recommend changes" about services provided or to be provided to them "without interference, or fear of coercion, discrimination or reprisal…"[30] This report is informed by both statutes, as well as the UNCRC, in addressing the importance of a young person's right to be heard.

WHAT WAS DONE TO UNDERSTAND THE REPORTS?

The Advocate's Office requested all SORs that had been submitted to the MCYS during the period of January 1, 2014 to March 31, 2014 (excluding those from youth criminal justice settings).[31] SORs submitted by youth justice facilities or other non-residential agencies (such as day programs) funded by the Ministry of Children and Youth Services or the Ministry of Community and Social Services were not considered within the scope of this review.

In response, the Advocate's Office received 5,030 individual reports, which were then scanned into a database for transcription and coding. The MCYS also provided information that 315 licensed residential programs did not submit any serious occurrence reports during this three-month period.

28 *Canadian Charter of Rights and Freedoms*, s7, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c11.
29 *Child and Family Services Act*, R.S.O. 1990 c.C11 s.107.
30 *An Act to enact the Child, Youth and Family Services Act, 2017 to amend and repeal the Child and Family Services Act and to make related amendments to other Acts* s.3.
31 Parker, C. (2016a). Request PACY2016-0010. Business Planning and Corporate Services Division. Ministry of Community and Social Services, Ministry of Children and Youth Services. February 5.

The MCYS redacted personal identifiers from the SORs before providing them to the Advocate's Office. During the transcription phase of the project, it became clear that there were fewer reports than expected. A follow-up request was sent to the Ministry and a second release of documents was obtained. A preliminary report dated February, 2016 presented the early findings of the review and was provided to the Residential Services Review Panel established by the MCYS. It was anticipated at that time that the numbers contained in the data analysis would change as the new data was integrated into the dataset. The new documents were compared to the original set and new reports were added, duplicates removed and incomplete reports excluded.

This current report includes the data from the SORs obtained in response to the second request and thus presents the complete findings. In the end, 4,436 reports were considered for this report. With the use of the data analytic software program CaseMap, each report was coded based on information gathered from each form.[32] Two human coders analyzed each report and applied a continuous sampling approach to testing for errors. This documentary analysis uses textual content analysis coding to describe the descriptive data gathered in the report.[33,34] The project team also met with interested service providers and the MCYS to gather their perspectives on SORs and the reporting mechanisms that currently exist.

It is important to keep in mind that there are several limitations to this descriptive analysis. The first limitation is that the reports are about serious occurrences and not about young people and their care. We learn from this report about what happens when serious situations occur, but we do not learn about care that occurs during other times that are not considered serious occurrences. Secondly, redacted information limits the ability to understand situations where multiple reports may relate to an individual child. Further, poor quality reporting makes it difficult to be sure that the reports accurately reflect the actions and responses that occurred during the incident. The SOR form is itself limited because the instructions direct service providers to describe only one of the eight types of occurrences. We have noted

32 Miles & Huberman (1994). *Qualitative Analysis: An expanded sourcebook*. Thousand Oaks: Sage Publications.
33 Prior, L. (2010). "Researching Documents: emergent methods in Hesse-Biber & Leavy" (Eds.) *Handbook of Emergent Methods*. New York. The Guilford Press.
34 Neuendorf, K. (2002) *Content Analysis Guidebook*. Thousand Oaks: Sage Publications.

that several reports had more than one box ticked for the type of occurrence. In order to be consistent with MCYS policy, a decision was made by the researchers to assess these situations and determine which of the eight types of occurrence best fit the information. Finally, a comparison across agencies is limited and complicated by the varying sizes of the residential programs that exist in the province of Ontario, with some agencies having one residence and others having several homes. In the end, we identified 205 agencies of varying sizes as having submitted SORs during the time period in question.

IS THE DATA ABSOLUTE?

No. The numbers contained in this report represent the total count of individual SOR submissions received from MCYS during the time period studied. Due to redactions, absolute data is not possible. Multiple sorts of the data were conducted to compare SORs by house name, date, and time to minimize the number of duplicates reported. Repeated sorting was conducted to remove duplicates; however, redactions beyond those that were anticipated limited the ability to find duplicates by date, agency and time. In total, 474 SORs, or 11% of the SORs received, had information redacted beyond what was expected.

Continuous review and sorting, including a close reading of the text contained in the SORs, identified most duplicates. It is possible that a small number of duplicates remain in the dataset. These duplicates are most likely to be within the missing person reports.

Despite these limitations, the findings provide a snapshot view of the number of serious occurrences during a three-month period, as well as clear confirmation that timely and rigorous analysis of SORs can act as an early alert mechanism and as an indicator of child-in-care well-being. The coding scheme that our researchers developed, based on legislative and best-practice standards, has allowed for data that provides a detailed lens into the nature and scope of these occurrences.

WHY DIDN'T THE PROVINCIAL ADVOCATE NAME AGENCIES?

Early in the review process, a decision was made not to name the individual agencies. This decision was arrived at because of several factors that impact on fairness. The first is that there is no comprehensive and complete dataset of licensed residences in which this data can be compared. Requests to the Ministry of Children and Youth Services produced substantial listings of agencies in different categories e.g. children's residences by site, foster care operators, lists including youth justice facilities, etc., which made it difficult to assemble one master list of all relevant licensees. Despite working in close co-operation, the Ministry of Children and Youth Services was not able to provide an accurate list of all licensed children's residences. Compounding the poor standards of reporting is the various house names that service providers use when reporting, which results in difficulties grouping residences by corporation. Further confusion results from the listing of a licensed provider by corporation number when service providers typically submit reports by agency or house name. Finally to be able to fairly compare agencies, it is necessary to have an accurate bed count in order to make cross-agency comparisons.

2. WHO ARE THE CHILDREN IN THESE REPORTS?

The Ministry of Children and Youth Services was not able to provide the exact number of children receiving service during the time period of this report (January 1, 2014 to March 31, 2014).[35] However, they confirmed that "the average number of children in the care of children's aid societies that were receiving services in children's licensed residential programs during this period was 12,646."[36] The Ministry of Children and Youth Services advised that occupancy rates are not calculated in any licensed home except for youth criminal justice facilities.

As noted earlier, the reports were redacted by the MCYS for identifiable information. Nonetheless, it was often possible to code the report by gender, whether or not a child had a disability, and if a children's aid society had been notified about the situation. It is important to point out that the numbers provided in this report refer to the number of serious incidents as specific events, and not to the number of children involved in serious incidents. There was no way to know if the same child was referred to in more than one report.

SEX OF THE CHILD

Where possible, the sex of the young person was determined for each report. Gender pronouns found in the body of the text were used to identify the sex of the child. Slightly more than half of the reports involved a male young person. For 485 of the reports, the gender could not be determined from the wording of the SOR.

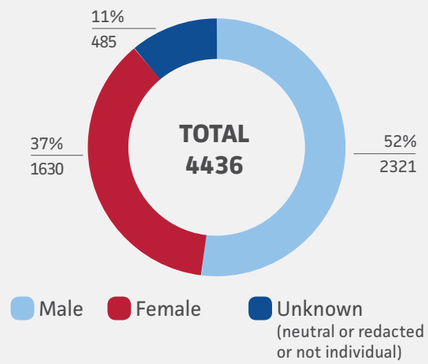
In 11% of the SORs, it was not possible to identify the sex of the person involved. This may have been due to the use of gender neutral language, an occurrence not related to an individual, or because of redaction. Somewhat more males were identified in the SORs than females.

GUARDIAN OF THE CHILD

Young people are placed in residential care by either a parent/guardian or a children's aid society. It is important to keep in mind when reviewing these statistics that the data refers to individual SORs and not children. As such, it is correct to understand that 378 of the reports relate to Crown Wards, not that there were 378 Crown Wards. This is because, as noted above, more than one report may relate to the same child.

In a majority of the SORs, a children's aid society is listed as the placing agent. In 17% of the SORs, the child is identified as being in parental care. In two SORs, reference to the parent was phrased as "adoptive parent."

SEX OF INDIVIDUAL INVOLVED IN SOR



PLACING GUARDIAN

	#	%
CAS as placing agent	3525	79
Parental care	758	17
Adoptive parents	2	<1
Unknown or not individual	151	3
TOTAL	**4436**	

35 Parker, C. (2016). Request PACY2016-0010. Business Planning and Corporate Services Division. Ministry of Community and Social Services, Ministry of Children and Youth Services.
36 Parker, C. (2016). Request PACY2016-0010. Business Planning and Corporate Services Division. Ministry of Community and Social Services, Ministry of Children and Youth Services.

YOUNG PEOPLE WHO ARE CROWN WARDS

Children are made Crown Wards when a judge finds that it is in the best interests of the young person to be removed from the care of their parent/s, and a children's aid society is entrusted with the permanent care of the child on behalf of the government. Crown Wards were sometimes identified by specific mention in the SORs.

Crown wardship was directly mentioned in 9% of the SORs. This likely underrepresents the number of occurrences where a Crown Ward was involved, as these could also be included among those that are only identified under the umbrella grouping of CAS Care.

YOUNG PEOPLE WHO ARE CROWN WARDS

STATUS	#	%
Crown Wards	378	9

YOUNG PEOPLE WITH DISABILITIES

All reports were classified by the research team as "yes," "no" or "possibly" with reference to whether the child had a developmental or intellectual disability. This was determined by (a) a direct reference to a disability in the SOR, or (b) by inferring this because the residence was known to specialize in caring for children with developmental disabilities, or (c) by a reference made to a Disability Guardian or Substitute Decision Maker. Reports were also coded if there was a direct reference to an assistive device such as a wheelchair. This underrepresents the true rate of disability, given that there was no way to consider invisible disabilities, head injuries, or mild cognitive delays. Young people with physical, intellectual and/or developmental disabilities are known to be at higher risk of abuse.[37]

YOUNG PEOPLE KNOWN OR SUSPECTED TO HAVE DISABILITIES

		#	%
Developmental disability	Yes	788	
	Possibly	381	
	SUBTOTAL	**1169**	26
	Other disabled	8	<1
TOTAL		**1177**	**27**

There were 788 SORs dealing with young people known to have a developmental disability and another 381 where it is suspected that the child does, representing 27% of the SORs.

FIRST NATIONS YOUNG PEOPLE

Reports where the placing agent was an Ontario First Nations-designated child welfare authority were counted as being related to First Nations young people. The analysis underrepresents the number of First Nation children in residential care, as it excludes those young people who are wards of a non-First Nations agency or who might have been placed by their parents or guardians.

The analysis identified 4% of the SORs where the placing agency was a First Nations organization.

SORs RELATED TO FIRST NATIONS CHILDREN

	#	%
First Nations	158	4

37 Hewitt, O. (2014). "A survey of experiences of abuse." *Tizard Learning Disability Review*, 19(3): 122-129.; Fisher, M.H., Baird, J.V., Currey, A.D. and R.M. Hodapp (2015). "Victimisation and social vulnerability of adults with intellectual disability: A review of research extending beyond Wilson and Brewer." *Australian Psychologist*, 51, 114-127.

CHILDREN LIVING FAR FROM HOME

Interprovincial care agreements are legal arrangements to care and provide for the child. Placed young people who are living away from their home community and province are particularly vulnerable due to their geographic isolation from their family and community and others who care about them. Based on the information obtained in this review, some of these arrangements include contracts with a local child welfare authority to oversee the placement for a child from out of province. In other cases, agencies brokering services on behalf of government and families make arrangements directly with the service provider without the involvement of a local child welfare authority.

Child welfare workers and families seeking services not available locally are forced to place an enormous amount of trust in strangers to look out for the well-being of the young person placed so far away from home.

OUT OF PROVINCE

Some of the reports relate to children sent to Ontario from other provinces. These children are receiving services such as children's mental health, or specialized fostering or residential care that is not available to them at home. Reports referring to a young person from outside of Ontario number 56.

More than half (57%) of SORs about out-of-province young people concern children from Newfoundland and Labrador. SORs about young people from Nunavut account for 25% of these reports. In two reports, the name of the province was redacted with only the statement "interprovincial agreement" written in the narrative.

This table below shows the type of occurrence by province of origin for the reports related to young people from out of province.

CHILD FROM OUT OF PROVINCE RECEIVING CARE IN AN ONTARIO CHILDREN'S RESIDENCE:

PROVINCE OR TERRITORY	#
Newfoundland and Labrador	29
Nova Scotia	11
Nunavut	14
Interprovincial agreement not otherwise specified	2
TOTAL	**56**

OCCURRENCE TYPE INVOLVING YOUNG PEOPLE FROM OUT-OF-PROVINCE

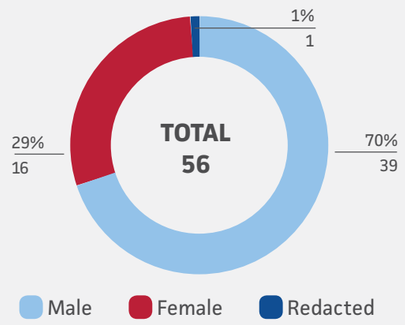
OCCURRENCE TYPE	Newfoundland and Labrador	Nova Scotia	Nunavut	Interprovincial agreement
1. Death of a client	0	0	0	0
2. Serious injury to a client	1	0	0	0
3. Alleged, witnessed, suspected abuse	3	0	0	0
4. Missing person	1	1	0	0
5. Disaster on the premises	0	0	0	0
6. Complaint about the operational, physical or safety standards	1	0	0	0
7. Complaint made by or about a client, or other serious occurrence involving a client	2	1	2	1
8. Physical restraint of a client	21	9	12	1
TOTAL	**29**	**11**	**14**	**2**

Complaints about standards or those made by or about a client account for 13% of the reports. Type *#8 Restraint of a Client* accounts for 77% of the SORs involving young people from out of province. One of the circumstances that add to the vulnerability of children living out of province is that placing agents may not be familiar with Ontario's rules about physical restraint. The researchers noted several potential issues in the SORs about physical restraints used with this particular group of young people. In 17 of the 43 reports, the type of physical restraint was not described, contrary to the *SOR Guidelines*. The use of more than one restraint within 24 hours is reported in 10 of the SORs (resulting in an actual total of 55 restraints). In seven of the reports, the text suggests that the young person was only assaultive after being physically engaged by the staff. These are possible 'red flags' that should prompt workers overseeing placements to seek more information to ensure the safety of the child. This is also a prime example of the potential use of SORs to safeguard children in residential care.

The table on the right identifies the sex of the young person indicated in SORs as being from out of province.

Most of the SORs about young people from out of province are reported to be male. In one SOR in this category, the sex was redacted.

SEX OF CHILD FROM OUT OF PROVINCE



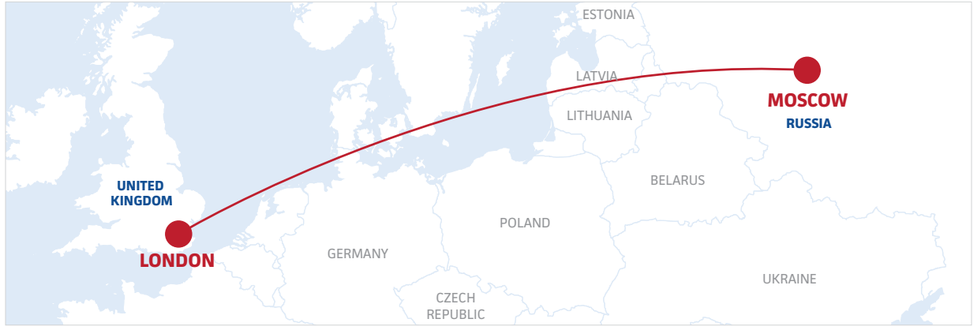
CHILDREN FROM REMOTE ONTARIO LOCATIONS

Some young people are also living very far from home, even though they are from Ontario. For example, 14 reports are about young people from Thunder Bay living more than 1,400 kilometers away from home. A more detailed analysis was conducted on the reports about young people placed by the two child welfare authorities operating in remote Ontario communities, both of which are First Nations agencies. (Remote communities are defined by the Federal government as those accessible only by air, with no year-round road access).

AGENCIES THAT SERVE REMOTE COMMUNITIES

Remote CAS (n=2)	#56

There are 56 SORs related to young people from remote Ontario communities. These young people are living at considerable distance from their home communities. Some of these young people are 3000 kilometers away from their home community — a distance comparable to travelling from London, England to Moscow, Russia. In reading the text of the SOR reports relating to these young people, the researchers noted that many young people let it be known that they were missing their family and wanted to be closer to home.



The first table on the right identifies the sex of the 56 reports about young people from remote Ontario locations.

There were 29 SORs that related to males from a remote community and 24 that referred to females. In three SORs the sex was redacted or missing. This next table presents the type of SOR reported for young people living away from a remote Ontario community.

More than half (54%) of the SORs about young people from remote Ontario communities involve physical restraints. *Type #7: Complaint made by or about a client, or other serious occurrence involving a client* accounts for 21% of these SORs. Nine of these reports are about medical or health concerns. Three reports are about young females who went missing and returned the same day.

SUMMARY

The vast majority of reports (79%) relate to a child placed at a home by a children's aid society. Slightly more than half of the reports are about young males and about one quarter of the reports (27%) are about young people who are known or suspected to have disabilities.

A total of 112 SORs are about children who are living very far away from their home communities. The review found 56 SORs regarding young people from out of province. An additional 56 SORs relate to young people from remote communities within Ontario. For these children, the distance from family and natural community advocates can increase their vulnerability.

SEX OF CHILD

SEX	#
Male	29
Female	24
Not known or redacted	3
TOTAL	**56**

TYPE OF OCCURRENCE FOR YOUNG PEOPLE FROM REMOTE LOCATION

OCCURRENCE TYPE	#
1. Death of a client	0
2. Serious injury to a client	8
3. Alleged, witnessed, suspected abuse	2
4. Missing person	3
5. Disaster on the premises	0
6. Complaint about the operational, physical or safety standards	1
7. Complaint made by or about a client, or other serious occurrence involving a client	12
8. Physical restraint of a client	30
TOTAL	**56**

3. THE EIGHT TYPES OF SERIOUS OCCURRENCES

There are eight types of serious occurrences that must be reported within specified time periods to the Ministry. *The Serious and Enhanced Serious Occurrence Reporting Guidelines* (2013) (herein referred to as the *SOR Guidelines*) spell out the necessary steps for notifying the Ministry that one of the designated types of incidents has occurred. These steps are:

1. Complete an "*Initial Notification Report*":
   - **A.** Within 24 hours of becoming aware of the incident, submit a *Serious Occurrence Report*

     OR
   - **B.** Within 3 hours of becoming aware of the incident, submit an *Enhanced Serious Occurrence Report* if emergency services (police, fire, or ambulance) are used in response to a "significant" incident and/or if the incident is likely to result in significant public or media attention
2. Inform the parent/guardian, and if applicable, the person or agency who placed the client. There is no timeline attached to this notification.
3. Within seven business days of submitting the *Initial Notification Report*, complete and submit an *Inquiry Report*. Conversely, a service provider may submit an *Inquiry Report* in lieu of an *Initial Notification Report* if all actions related to the incident have been completed and documented within 24 hours.

The *SOR Guidelines* also give service providers an evening and weekend *Enhanced Serious Occurrence* fax and phone line for receiving reports of *Enhanced Serious Occurrences* to be submitted within three hours of becoming aware of the incident.

In this next section, the overall number of reports submitted is presented by occurrence type. The *Preliminary Report* provided an initial accounting of this information and this section is an update of that document.

To begin, the total number of reports was considered by each of the eight types of occurrence. Reported in this section are the combined data from both requests, excluding all duplicates.

Of all of the reports reviewed, *Type #8 Restraint of a Client*, accounts for the largest number of SORs submitted to the MCYS during this time period, accounting for half of all the reports. The next largest number *Type #7 Complaint made by or about a client, or other serious occurrence involving a client*, comprises 20% of all of the reports. The third highest number of reports relates to *Type #4 Missing Person* with a total of 799 occurrences (18%). These three types of occurrence accounted for 88% of all reports submitted. The remaining five types of serious occurrence together represent 12% of the reports received.

FREQUENCY BY TYPE

FREQUENCY BY TYPE OF OCCURRENCE	#	%
1. Death of a client	18	<1
2. Serious injury to a client	329	7
3. Alleged, witnessed, suspected abuse	115	3
4. Missing person	798	18
5. Disaster on the premises	18	<1
6. Complaint about the operational, physical or safety standards	47	1
7. Complaint made by or about a client, or other serious occurrence involving a client	881	20
8. Physical restraint of a client	2230	50
TOTAL	**4436**	-

TYPE #1: DEATH OF A CLIENT

The first category of a serious occurrence is the death of the child.

The *SOR Guidelines* require a report for any:

Death of a client which occurs while participating in a service, including all clients receiving community-based support services funded or licensed by the MCSS and/or the MCYS. As well, it includes:

- any child receiving service from a children's aid society at the time of his/her death or in the 12 months immediately prior to his/her death, or
- any violence against women (VAW) client death that occurred at a VAW agency or as a result of intimate femicide (at the hands of her abuser) while in the receipt of service.

The reason documented for the death is provided in the table on the right.

There were 18 reports of death of a child. There were no homicides reported during this time period. Two young people died by suicide, one while on the waiting list for services. One death was unexpected. The second phase of data gathering did not include further reports of the death of a client. One duplicate was identified when comparing the initial batch of SORs with the second dataset, reducing the total number of deaths initially reported by one. The *Preliminary Report* raised concerns about the adequate documentation of child death, particularly in situations of disability and where the child is a Crown Ward. The reader is directed to that report for further information on this category.

DEATH OF CHILDREN: JANUARY 1, 2014 TO MARCH 31, 2014

RECORDED REASON FOR DEATH	#	%
Suicide	2	11
Palliative	4	22
Medically Fragile	4	22
SUDI*	5	28
Disability/Obesity	2	11
Unexpected other (pre-op)	1	6
TOTAL	**18**	-

* Sudden unexplained death of an infant

Ministry of Community and Social Services
Ministry of Children and Youth Services

Ontario

Serious Occurrence Report
(TO BE SUBMITTED WITHIN 24 HOURS OF INCIDENT)

SECTION C: DETAILS OF SERIOUS OCCURRENCE

SUMMARY OF OCCURRENCE – ☐ *tick if other pages are attached*
What, where and when it happened, including actions taken by the service provider
For physical restraint reporting, please include: current status/condition, person's views/allegations and service provider action

Patient died due to illness. Death expected

MEDIA INVOLVEMENT: ☐ Yes ☒ No

WHO HAS BEEN NOTIFIED?
☐ Police
☒ Parent(s) / Guardian(s)
☐ Individual acting on behalf of the person with a developmental disability
☐ CAS PLEASE SPECIFY:
☒ Other PLEASE SPECIFY: PHYSICIAN
PLEASE SPECIFY:

FURTHER ACTION PROPOSED BY SERVICE PROVIDER
☐ *tick if other pages are attached*

DIRECTION, IF ANY, PROVIDED BY MINISTRY – ☐ *tick if other pages are attached*

TYPE #2: SERIOUS INJURY TO A CLIENT

The *SOR Guidelines* require reports of all serious injuries that occur while participating in services.

A serious injury may include:

Medication errors that resulted in an injury/illness which may include:

- client receives the wrong medication;
- the wrong client receives the medication;
- client receives the medication at the wrong time;
- client receives the wrong dosage of medication;
- failure to document the administration of medication;
- no documentation;
- wrong route of administered medication;
- Injuries (consider whether an injury should be reported if professional medical treatment such as a doctor or dentist, is required, no in-house first aid), which may include:
  - an injury caused by the service provider, e.g., lack of or inadequate staff supervision, neglect/unsafe equipment, improper/lack of staff training, medication error resulting in injury;
  - a serious accidental injury received while in attendance at a service provider setting, and/or while receiving service from the service provider, e.g., sports injury, fall, burn, etc.;
  - a serious non-accidental injury, e.g., suicide attempt, self-inflicted or unexplained injury and which requires treatment by a medical practitioner including a nurse or dentist.

The fourth largest number of SORs submitted relate to *Type #2 Serious Injury to a Client*.

The total number of serious injuries reported under this category is 329, comprising 7% of the submitted SORs. It is, however, important to keep in mind that injuries were also noted in other types of serious occurrences and the ones reported in this section are only the 329 reports submitted as *Type #2*. In the 90-day period under review, there was an average of 3.7 serious injuries each day. The next table provides a breakdown of the nature of the serious injuries reported as such.

Accidental injuries, very often sports injuries or childhood play injuries, account for 25% of the reports. Reports under *Type #2: Serious Injury* include five motor vehicle accidents, three in which a child was hit by a car, and two where the child was in a vehicle that was in a motor vehicle accident. Six serious injuries were reported as occurring in the context of physical restraint by staff and five reports were about serious injuries resulting from assault, most often by a peer.

There is a high rate of self-harming behaviour. Self-inflicted injury accounts for 40% of the reports. More than one type of self-harming behaviour may have been reported, but for coding purposes, the dominant form of deliberate self-harming behaviour is reported. This next table presents the types of known deliberate self-harming behaviours reported.

TYPE OF OCCURRENCE

	#	%
Serious Injury	329	7

TYPE OF INJURIES REPORTED

TYPE OF INJURY	#	%
Occurred during restraint	6	2
Accidental	83	25
Assault	5	2
Mental health crisis	36	11
Self-inflicted — unexplained	12	4
Self-inflicted — explained	120	36
Medical — known	34	10
Medical — unknown	4	1
Medication error	29	9
TOTAL	**329**	**-**

Self-harming by cutting was reported in 40% of reports of known self-inflicted injury. A young person ingested a noxious substance in 21% of these reports, in one case ingesting bleach. In five reports, the young person tried to choke or hang themselves. The young person swallowed a foreign object in 9% of reports, including one situation where the young person swallowed a plastic knife. Deliberate self-harming (DSH) behaviour is further discussed in Chapter 7.

TYPE #3: ALLEGED, WITNESSED OR SUSPECTED ABUSE

The abuse of children in residential care has been a concern since the awareness of child maltreatment came into the public light and from repeated disclosures of historical abuses in institutional care. Additionally, the young people who are the subject of the reports in this review are for the most part placed in these homes by a children's aid society (a children's aid society is the placing agent in 79% of the SORs in this review). The involvement of a child protective service denotes a population already affected by child maltreatment. This heightens their vulnerability to further victimization. There is a known risk associated with out-of-home care in particular for those with disabilities, those away from kin and natural advocates and those in totally or partially closed environments.[38]

Under the category *Type #3: Alleged, Witnessed or Suspected Abuse,* there was a total of 115 reports. Eleven of these reports involve Crown Wards and four involve First Nations young people. The police were notified in 30 of these reports. Twenty reports relate to allegations of sexual assault, and it is reported that medical attention was sought in two situations.

Allegations of abuse by staff or foster parents account for 31% of the reports under this category. A similar number of allegations were made against family members. Allegations of abuse do not necessarily mean that the abuse has been verified, rather that these are reports of the untested allegation. This next table gives the number of reports about witnessing abuse.

38 Wardhaugh, J. & Wilding, P. (1993). "Towards an explanation of the corruption of care." *Critical Social Policy* 13(4), 5-31.

KNOWN TYPES OF DELIBERATE SELF-HARM (DSH)

DELIBERATE SELF-HARM (DSH)	#	%
Cut self	48	40
Hurt hand, punch or bang	20	17
Poison self or ingest noxious substance	25	21
Burn self	1	<1
Swallow foreign objects	11	9
Choke or hang self	5	4
Bang head	2	2
Other, redacted or not described	8	7
TOTAL	**120**	*

* Exceeds 100 due to rounding

ALLEGED ABUSE

ALLEGATION	#	%
Alleged abuse by staff	11	10
Alleged abuse by foster parent	23	21
Alleged abuse by foster parent's child	1	<1
Alleged abuse by peers	11	10
Alleged abuse by family member	34	31
Alleged abuse by a teacher	2	<1
Alleged abuse by a community member	11	10
Alleged abuse by former adoptive parent	1	<1
Alleged abuse during restraint (staff or foster parent)	15	14
Alleged abuse by unknown person	1	<1
Alleged abuse by the child	1	<1
TOTAL	**111**	**-**

There was one report of witnessing abuse. This report follows police involvement with a family and reported by the police.

There were three allegations of suspected abuse. In one situation, the report referred to a disclosure by a young person about a historical sexual assault. Another was reported by the police to notify a society that a foster parent had been charged with possessing child pornography. The third was a report about a child in care witnessed to have scratches and bruising on his face.

DISPOSITION OF ALLEGATION

The children's aid societies and the police are responsible for the investigation of all allegations of abuse. The primary sources of investigative information about these situations should be contained in the police and society files. Nevertheless, the outcome or disposition of the investigation was identified in a majority of SORs of this type. Reports may lack a disposition due to ongoing investigation, with a future report to be submitted beyond the date of this analysis.

There was a final outcome to allegations of abuse in 31 situations. In each of these cases, the matter was investigated either by a children's aid society or by the police. The results of the investigations are as follows: 21 unsubstantiated cases, seven substantiated cases, and three inconclusive cases. In some cases, the investigation may have been completed outside the time period covered in this review. In 44 cases, no information was provided about the outcome of the investigation. This could be because in 17 cases, the determination was to take no further action, and in 23 occurrences, a safety plan was put into place. For example, reports may indicate that the child was moved to a respite home, or that certain children cannot be left alone with each other.

TYPE #4: MISSING PERSON

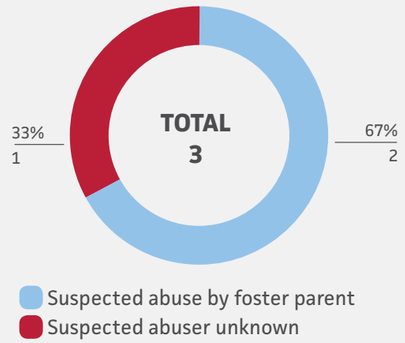
The last table on the right shows the total number of SORs about a missing child. These reports were also more likely to generate multiple reports in this time period.

Reports about missing young people account for 18% of the total SORs submitted. While numerous reports are generated, these reports contain very little information. This type of occurrence will be discussed more fully in Chapter 6.

WITNESSED ABUSE

WITNESSED	#	%
Witnessed abuse by a family member	1	100

SUSPECTED ABUSE



DISPOSITION OF ALLEGATION

DISPOSITION	#	%
Substantiated	7	6
Unsubstantiated	21	18
Inconclusive	3	3
No further action	17	15
Safety plan	23	20
No information provided	44	38
TOTAL	**115**	-

MISSING CHILDREN

SORs	#	% of all SORs
Reports of children missing	798	18%

TYPE #5: DISASTER ON THE PREMISES

Disasters on the premises where a service is provided, that interferes with daily routines, e.g., fire, flood, power outage, gas leak, carbon monoxide, infectious disease (where public health official are involved) lockdown, etc. These are situations that interfere or disrupt the daily routines of the residence. In total there were 18 disasters reported (see table on right.)

The largest number of incidents reported during this time period described fires at a children's residence. No injuries were reported from these fires. There were two bomb threats to programs and one break-in. Two SORs referred to service disruption due to inclement weather and three reports related to adverse water testing readings.

DISASTER ON THE PREMISES

TYPE OF DISASTER	#	%
Fire	7	39
Bomb threat	2	11
Break-in/Theft	1	6
Building unsafe	2	11
Alarm activated	1	6
Service disruption	2	11
Adverse water reading	3	17
TOTAL	**18**	*

* Exceeds 100 due to rounding

TYPE #6: COMPLAINT ABOUT OPERATIONAL, PHYSICAL OR SAFETY STANDARDS

The sixth type of occurrence is a complaint about operational, physical or safety standards of the service that is considered serious by the service agency. There were 47 reports submitted in this category.

The largest number of SORs of this type, accounting for almost half of these report, relate to errors administering medication. Four additional allegations about foster parents, three allegations against staff and three allegations about abuse during a physical restraint are incorrectly reported under this category.

COMPLAINT ABOUT OPERATIONAL, PHYSICAL OR SAFETY STANDARDS

CATEGORY	SUB CATEGORY	# OF INCIDENTS
Operational standards	Medication error	23
	Privacy breach	1
	Complaint by a neighbour	1
	Adverse water reading	4
Physical standards	Physical plant unsafe	1
Safety standards	Alarm activated	1
	Allegation about staff	3
	Allegation about foster parent	4
	Allegation in the context of restraint	3
	Staff charged	1
	Young person charged	1
	Foster parent charged	1
	Peer charged	1
	Police attend	1
	Young person's safety at risk	1

TYPE #7: COMPLAINT MADE BY OR ABOUT A CLIENT, OR OTHER SERIOUS OCCURRENCE INVOLVING A CLIENT

Complaint made by or about a client or any other serious/enhanced serious occurrence involving a person participating in a service that is considered by the service agency to be of a serious nature, (e.g., police involvement with a client; assault by a client; assault by a client against staff, peers or community member; hospitalization, inappropriate disciplinary techniques; and complaints arising from sexual contact between clients). This category includes a very wide range of serious events that occurred. During service provider consultations, the team heard widespread agreement that this type of SOR needs to be sub-categorized in order to provide a meaningful understanding of the nature of these incidents. The tables generated below have categories developed after reading the narratives and are examples of the benefit of further defining this type of occurrence. A total of 881 SORs were submitted as this type. These three tables on this page detail the nature of these occurrences.

The largest number of complaints made by a client referred to assault. A total of 67 assaults were reported in SORs of this type. There are 11 reports of assaults by staff and six reported assaults by a foster parent. These incidents are distinct from those reported under *Type #3, Alleged, Witnessed, or Suspected Abuse*, the category under which they should have been reported.

Of the *Type #7* reports, 22% relate to police interaction with a young person. Sometimes this involvement is in relation to a youth criminal justice matter and other times in regard to the young person's own experience of victimization. The young person's assaultive behaviour is the subject of 16% of these types of SORs.

A medical crisis, either related to physical or mental health, accounts for 22% of all reports in this category. A serious concern or allegation, often an allegation of historical abuse, was reported in 57 SORs. A further 18 motor vehicle accidents were reported as this type of occurrence.

COMPLAINT MADE BY A CLIENT

COMPLAINT MADE BY A CLIENT	#
Assault by staff	11
Assault by a foster parent	6
Assault by peer	29
Assault in the community	21
Concern with family interaction	5
Complaint about service	11
Theft	3
SUBTOTAL	**86**

COMPLAINT MADE ABOUT A CLIENT

COMPLAINT	#
Allegation of assault against another young person	142
Police matter about a young person	193
Neighbour complaint	6
SUBTOTAL	**341**

OTHER SERIOUS CONCERNS ABOUT A CLIENT

OTHER SERIOUS CONCERNS	#
Medical crisis Medical crisis: physical (100) Medical crisis: mental health (192)	292
Drug or alcohol crisis	6
Motor vehicle accident	18
Uninvited guest	6
Conflict with client parent	8
Medication error	20
Service disruption	16
Service breach	5
Serious concern or allegation	57
Other serious concern	26
SUBTOTAL	**454**

An additional 20 medication errors were reported as *Type #7*. Medication errors were observed to be reported in three types of SOR categories (*Type #2 Serious Injury, Type #6 Complaint about operational, physical or safety standards* and *Type #7 Complaint made by or about a client, or other serious occurrence involving a client*). Despite instructions that medication errors should be recorded in either "*Type #2 Serious Injury*" or "*Type # 6: Complaint About Operational, Physical, Safety Standards,*" a total of 20 incidents was recorded under *Type #7*. A more thorough discussion of medication errors can be found in the companion report.

TYPE #8: RESTRAINT OF CLIENT

The *SOR Guidelines* define physical restraint used with children as:

> *a holding technique to restrict a resident's ability to move freely*
>
> *see Child and Family Services Act (CFSA) R.R.0. 1990, Regulation 70, Sections 109.1-109.3.*

This definition also excludes several less intrusive physical restrictions from being considered restraint:

> Does not include the restriction of movement, physical redirection or physical prompting if the restriction of movement is brief, gentle and as a part of a behaviour-teaching program, or the use of helmets, protective mitts or other equipment to prevent a resident from physically injuring or further physically injuring himself or herself.[39]

The Ministry of Children and Youth Services has approved six training methods for use in licensed children's residential settings. These are known and described in the SORs as CPI (the Crisis Prevention Institute); CTI (Canadian Training Institute); UMAB (Hy'N'Hancement Consulting Inc.); PMAB (Preventing and Managing Aggressive Behaviour Focus Group and Satori Learning Design Alternatives); TCI (Cornell University) and SMG (Safe Management Group). Each of these programs teaches one-to three-day courses that include segments on self-defence and release (e.g. releasing from a bite), de-escalation strategies and a sequence of least-intrusive to full-control physical restraint.

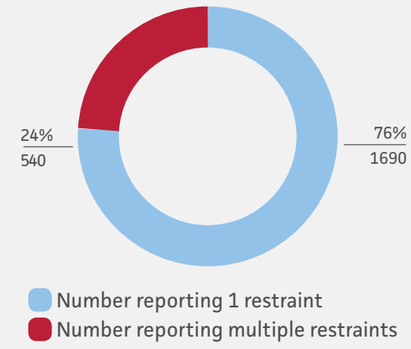
The total number of SORs forms submitted about physical restraints is presented below (The physical restraint of young people is discussed more fully in Chapter 8).

Half of all SORs submitted are about the physical restraint of a young person. The second table on this page shows the number of reports that identify more than one restraint (as permitted by the *SOR Guidelines*). It is important to note that the numbers in this table refer to restraints that occurred at least five minutes after the full release of a young person from an earlier restraint. The research team decided that if a child was released from a restraint, but was restrained again after five minutes ("unsuccessful release"), this was counted as a single restraint. This was to prevent double counting situations where the child had not been fully released from the first physical restraint.

TOTAL NUMBER OF FORMS

TYPE OF OCCURRENCE	#	%
#8 Restraint of a Client	2230	50%

NUMBER OF REPORTS DESCRIBING A SINGLE AND MULTIPLE RESTRAINTS



39 Ministry of Community and Social Services/Ministry of Children and Youth Services (2013). *Serious and Enhanced Serious Occurrence Reporting Guidelines* p.3.

There were a total of 2,230 reports with 540 reporting more than one incident about *Type #8 Restraint of a Client* submitted in this 90-day period.

A total of 3,599 restraints were reported during the review time period. This indicates that in Ontario, every day, on average, 40 restraints are used in a children's residence. A more complete discussion about the use of restraints is forthcoming in Chapter 8.

SUMMARY

Physical restraints account for the largest number of SORs submitted to the Ministry during this time period, comprising half of all the reports. The next largest number *Type #7: Complaint made by or about a client, or other serious occurrence involving a client*, accounts for 20% of all of the reports. The third highest number of reports refers to *Type #4: Missing Person* with a total of 799 occurrences (18%).

Medication errors, peer-on-peer violence and child-in-care victimization are reported across a number of occurrence types. As a result, the true rate of these types of incidents is not as readily apparent as it could be. Further discussion of victimization is presented in Chapter 4 and issues related to the tabulation of medication errors are discussed in Chapter 5.

TOTAL NUMBER OF RESTRAINTS REPORTED

# RESTRAINTS IN REPORT	# OF REPORTS	TOTAL NUMBER OF RESTRAINTS
1	1690	1690
2	0	0
3	376	1128
4	106	424
5	28	140
6	13	78
7	8	56
8	5	40
9	0	0
10	1	10
11	3	33
TOTAL		**3599**

SORs AND NUMBER OF RESTRAINTS

Total number of reports	2230
Total number of restraints	3599

4. THE VICTIMIZATION OF CHILDREN IN RESIDENTIAL CARE

REPORTS OF VICTIMIZATION

When exploring the victimization of young people living in children's residences, the logical place to start might be to analyze *Type #3: Alleged, witnessed, suspected abuse*. Relying only on this measure, however, would produce incomplete results. It is therefore necessary to aggregate (add together) information from multiple occurrence types to obtain a more accurate picture of victimization.

In addition to *Type #3: Alleged, witnessed, suspected abuse*, reports of victimization were often recorded as either *Type #7: Complaint made by or about a client, or other serious occurrence involving a client* or as *Type #2: Serious injury to a client*. This manner of reporting is consistent with the *SOR Guidelines*. As a result, the true rate of child-in-care victimization is obscured and made difficult to determine because of the structure of the SOR form itself, and the various allowable options for reporting this information.

Another complicating factor relates to *Type #2: Serious injury to a client* because the only choices offered on the form is that the injury was a) caused by service provider, b) accidental or c) self-inflicted/unexplained. This would mean that an injury caused by an assault by a peer or a community member would by default be coded as b) accidental. This next example is a case in point.

This SOR is a follow-up report coded as a *Type #2 Serious injury to a client* b) accidental. The report is about a young person who was assaulted.

> *"[A young person] with a female peer was assaulted by two adult peers with baseball bats while at <redacted>'s home. He sustained a large split under his eye. The female peer, not associated with <the residence> sustained head injuries which required staples at the hospital...The two adults were arrested and charged with break and enter and assault with a weapon."*

SECTION B: TYPE OF SERIOUS OCCURRENCE (report only one from the following)

☐	1. Death CORONER NOTIFIED? ○ Yes ○ No ○ Unknown By whom:	☐	5. Disaster on premises PLEASE SPECIFY:
☑	2. Serious injury: ○ a) Caused by service provider ◉ b) Accidental ○ c)Self-inflicted/unexplained	☐	6. Complaint about service standard (include adverse water quality)
☐	3. Alleged abuse/mistreatment	☐	7. Other (Complaint made about client or other Serious Occurrence)
☐	4. Missing client (Note: Ministry must be notified of final outcome)	☐	8. Use of physical restraint ○ a) No injury ○ b) resulting in injury ○ c) allegations of abuse **(Note: Physical Restraint is not permitted under the *Day Nurseries Act*)**

In order to calculate the actual rate of victimization, an analysis of all the categories was conducted to give a more accurate representation of victimization recorded in this 90-day period.

YOUNG PEOPLE AT RISK FROM OTHERS

There were 10 reports indicating that the young person was at risk from others in the community. These include three threats made over Facebook, two reports of young people at risk of ongoing sexual exploitation and human trafficking, two situations involving risk from peers in the community, one issue involving texting with an unknown adult, and two reports of risk posed by community or family members.

These reports described various measures put in place to attempt to protect the youths. As an example, the three reports about threats of harm over Facebook resulted in increased monitoring of social media and supervision of the young people.

ALLEGATIONS OF THE SEXUAL ASSAULT OF YOUNG PEOPLE IN CHILDREN'S RESIDENCES

There were 56 disclosures of sexual assault reported during the review period. None of the sexual assaults identified was reported as a serious injury. Only eight of these reports document that the young person was provided medical attention. In seven of these, the young person underwent a sexual assault exam at a hospital and in one case the young person was involuntarily committed to a psychiatric unit at a hospital.

There were eight reports of historical abuse more than a year old and the remaining 48 reports contained allegations of sexual assault occurring within one year prior to the report. Fifteen of these allegations are related to victimization by peers in care. Four incidents were reported of sexual assaults that occurred while the young person was missing from the residence. There were two reports of sexual exploitation. In one of these reports, the young person was found with a "pimp," being exploited in the sex trade and in the other, the young person was exploited by a peer in order to obtain drugs.

ALLEGED SEXUAL ASSAULT

ALLEGATION TYPE	#	%
Historical sexual abuse >1yr	8	14
Allegation of a sexual assault by a peer in care	15	27
Allegation of sexual assault while AWOL	6	11
Sexual assault of young person in community	20	35
Sexual assault of young person by a family member	4	7
Sexual exploitation	2	4
Sexual assault by foster parent or staff	1	2
TOTAL	**56**	**-**

It is important to recognize that this count does not identify all the situations of sexual assault. Sexual assault is not always explicitly documented in the SOR and in a number of cases sexual assault was implied, but not mentioned. As an example, the following SOR refers to a young person who was returned to a residence by the police after having been missing for several days. The police report that she had been found at a known "crack house."

> *"She also revealed the name of her 'boyfriend,' who is a convicted sexual offender (police aware). It is to note, that when youth was picked up she was smelly, found with no pants on, and laying on a bed. An adult male known to the criminal justice system owned the home, and was present, along with her 'boyfriend' (police aware). Youth was on her menses, and had no hygiene products or underwear with her."*

ALLEGATIONS OF ASSAULT BY PEERS IN A CHILDREN'S RESIDENCE

Reports of assaults allegedly perpetrated by a peer were also examined. This information was identified in the narrative and captured in reports about *Type #7: Complaint made by or about a client, or other serious occurrence involving a client*, *Type # 3: Alleged, witnessed, suspected abuse, Type #8: Restraint of client* and *Type #2: Serious injury to a client.*

Peer-on-peer violence was reported in 30 SORs. Five of these were reported as allegations of abuse and three reports submitted as serious injury. Peer-on-peer violence was implicated as a precipitant to a restraint in four situations and as a factor in 18 complaints.

REPORTING TYPE OF PEER-ON-PEER VIOLENCE

OCCURRENCE TYPE	#
Complaint by or about a client or other serious occurrence	18
Alleged, witnessed or suspected abuse	5
Restraint	4
Serious injury	3
TOTAL	**30**

DISCUSSION ON VICTIMIZATION

Young people in the care of a children's aid society, having been subjected to abuse during critical developmental stages, may at times lack the capacity to keep themselves safe and accurately appraise the safety of situations. Prior trauma, often at the hands of, or in complicity with, trusted adults, can distort their perception of safety and impair their self-protective impulses. As dependents, sometimes, passivity and acceptance of abuse becomes a dominant coping strategy. Those seeking to prey on children develop the ability to identify those who have been rendered vulnerable by their childhood trauma.[40]

This analysis found 56 distinct sexual assaults disclosed during the three-month review period. (If this pattern is consistent, then it suggests that over a 12-month period there could be as many as 224 incidents of sexual assault reported across the province). Fifteen of the sexual assaults were alleged to be perpetrated by a peer in the residence. A majority of the sexual assaults occurred while the young person was away from the residence, either while "AWOL" (n = 6) or while out in the community (n = 20). There were four reported allegations of familial abuse.

In addition to reports of sexual violence, there were 30 reports of peer-on-peer violence with five resulting in a serious injury. These are the situations where a direct assault by a peer is recorded in the SOR. These do not include the 374 situations, mostly involving the use of physical restraint, where the precipitating event is described as a peer conflict, but there is no explicit statement that an assault occurred.

There needs to be a reconsideration of how incidents of victimization and sexual assault and exploitation is reported and recorded. The structure of the SOR form does not allow for easy access to this important data. For example, if someone wanted to find out how many sexual assaults against children in care were reported in the 90-day period of this review, they would minimally need to look at *Type #3: Alleged, witnessed, suspected abuse, Type #2: Serious injury to a client* and *Type #7: Complaint made by or about a client, or other serious occurrence involving a client* because this is how agencies and service providers are reporting these types of incidents. Additionally, there is no explicit requirement to report peer-on-peer violence (nor is there an obvious category in which to do so). As it stands, the current serious occurrence reporting system structurally obscures the true rate of victimization of vulnerable children in care.

40 Euser, S., Alink, L.R.A, Tharner, A., van Ijzendoorn, M.H and M.J. Bakermans-Kranenburg (2014). "The prevalence of child sexual abuse in out-of-home care: Increased risk for children with a mild intellectual disability." *Journal of Applied Research in Intellectual Disabilities*, 29, 83-92.

5. WHEN POLICE OR EMERGENCY SERVICES ARE CALLED TO CHILDREN'S RESIDENCES

To better understand the issues surrounding contact with police or emergency services in the residential care system, it is necessary to determine what triggered a call to police and how the police responded.

The SOR form contains a box to indicate whether the police were notified about an incident. It would appear that police involvement is usually in the context of an emergency 911 call. Notification of police was determined in the first sweep of data by a simple yes/no code indicating whether the box had been ticked. It is important to understand that this review reports on the SORs submitted that include police or emergency services involvement and does not capture all situations where police attend a residence.

In 32% of the SORs, the police were notified of the occurrence as determined by the checked box. This review then looked at any mention of police involvement in the description of the occurrence, whether or not the police notification box had been checked off on the form. There were 182 such reports of police contact in the narrative descriptions that were not indicated in the notification check box.

The numbers in the second table combine those reported in the notification section and those that were coded as such based on the written narrative.

When both measures of police contact are combined, it became clear that 36% of SORs resulted in police contact. This indicates that one in three of the SORs involved the police. These combined numbers are the ones used in this analysis of police involvement in this three-month period. Therefore, there was an average of almost 18 police contacts per day at children's residences reported during this time period.

The last table to the right breaks down the type of serious occurrence that triggered a call to the police.

In just under half of the occurrences where the police were notified, it was to report that a young person had gone missing. The second largest number of contacts falls under *Type #7: Complaint made by or about a client, or other serious occurrence involving a client*. As mentioned earlier, subcategories are needed to make sense of the large variety of incidents recorded under this category.

NUMBER OF POLICE REPORTS WHERE THE POLICE NOTIFICATION BOX WAS TICKED

NOTIFICATION	#	%
Police notified	1413	32
No police contact	3023	68

POLICE INVOLVEMENT DESCRIBED

CONTACT	#	%
Police contact	1594	36
No police contact	2842	64

TYPE OF OCCURRENCE

OCCURRENCE TYPE	#	%
1. Death of a client	6	<1
2. Serious injury to a client	78	5
3. Alleged, witnessed, suspected abuse	33	2
4. Missing person	774	49
5. Disaster on the premises	8	<1
6. Complaint about the operational, physical or safety standards	11	<1
7. Complaint made by or about a client, or other serious occurrence involving a client	545	34
8. Physical restraint of a client	139	9
TOTAL	**1594**	**-**

The first table on the right provides a set of descriptors or subcategories that identify the specific nature of the police visit for situations classified as *Type #7 Complaint made by or about a client, or other serious occurrence involving a client.*

Physical or mental health crises account for 24% of the occurrences reported under *Type #7*. The young person had been accused of an assault in 24% of these reports and the young person had reported an assault in 8% of them. In 33% of these reports, the contact related to an ongoing police matter involving the young person, including matters where the young person was accused of an alleged crime, or the victim of an alleged crime. Other serious occurrences included: thefts, conflict with parents, service disruptions and other police matters concerning the child.

It is important to consider both the context of police involvement and the outcome of the contact. There is no instruction in the *SOR Guidelines* to report on the outcome of the police involvement, but the researchers found that this could often be determined by reading the narratives. The last table on the right reports on the outcome of police involvement.

The most common reason (55%) for police contact or attendance at a children's residence in this review was to file a Missing Person Report or to notify the police of a pending report. In 11% of the contacts, the young person was transported by the police to a hospital during a mental health crisis. Young people were charged in relation to events at the residence in 68 of the occurrences and were detained, often with regard to prior events, in 202 occurrences. Together, young people who were charged or detained account for (270) 17% of police contacts at a children's residence. Young people were interviewed by police, most often about their own victimization, in only 6% of the contacts.

TYPE #7 COMPLAINT MADE MY OR ABOUT A CLIENT, OR OTHER SERIOUS OCCURRENCE INVOLVING A CLIENT WITH POLICE INVOLVEMENT

COMPLAINT BY OR ABOUT OR OTHER	#	%
Medical crisis	9	2
Mental health or drug or alcohol crisis	121	22
Assault by the client	131	24
Young person alleges assault	46	8
Motor vehicle accident	11	2
Neighbour complaint	6	1
Uninvited guest	6	1
Ongoing police matter involving young person	180	33
Serious allegation	15	3
Other serious occurrence	20	4
TOTAL	**545**	**-**

OUTCOME OF POLICE INVOLVEMENT OF ALL CONTACTS

OUTCOME	#	%
Police notified/report filed	870	55
Police attended to caution young person	125	8
Police took to hospital	171	11
Police charged young person	68	4
Police detained young person or warrant	202	13
Police interviewed/ photographed/subpoenaed	103	6
Police attended or 911 and no other information	47	3
Police called but did not attend	8	<1
TOTAL	**1594**	*****

* Exceeds 100 due to rounding

Most of the criminal charges recorded against young people related to events that occurred outside the residence. When young people were detained or charged, most frequently it related to a prior criminal justice matter or as a result of breaching a bail condition. It is clear that when young people are missing, at times they end up in conflict with the law and very often accumulate charges of breaching existing bail terms or probation conditions. Most instances of aggression and property damage recorded in these SORs did not result in charges. In some situations (primarily reported under *Type #7*), young people did end up with charges following behaviours that had occurred in the residence. The table to the right identifies these situations.

REASON FOR POLICE CONTACT BY OCCURRENCE TYPE

REASONS FOR CONTACT	#7: COMPLAINT BY OR ABOUT A CLIENT OR OTHER SERIOUS OCCURRENCE INVOLVING A CLIENT	#8 RESTRAINT OF CLIENT
Breach of conditions	24	2
Assault on peer	10	0
Assault on staff	14	13
Theft	1	0
Mischief (property damage)	28	3
Uttering threats	8	2
Possession of banned substance	6	0
TOTAL	**91**	**20**

Combining the total number of charges following the use of a physical restraint and/or reported as *Type #7*, the number of criminal charges related to events at the residence totals only 3% of reports. Mischief charges from causing property damage comprises 39% of the charges. Breaches of conditions were cited in 23% of these reports. The vast majority of reported assaults on staff and damage to property were managed without emergency response. When police were called in this context, it was most likely involved in either cautioning the young person or taking the young person to the hospital.

This next case situation from an SOR, submitted by a children's mental health centre, describes indicators that a child is experiencing a mental health event and it is the police who decide she must be taken, involuntarily, to the hospital due to her suicidal ideation. This was reported as *Type #7: Complaint made by or about a client, or other serious occurrence involving a client.*

> *"Alisha present[ed] with suicidal ideation, telling staff that she wanted to kill herself. Staff encouraged her to draw upon management skills and staff staff [sic-stay] within sight. She refused and headed to her bedroom. Staff followed and then she locked herself in her closet. Upon hearing concerning noises staff used code to enter the closet. Alisha upset, still threatening self-harm and threatening to leave the building, which she did but returned 40 minutes later. The police had been called and arrived after she returned. Staff reported that Alisha is claiming that she is hearing voices and wanted to kill herself. Police determined that she would need to be seen at hospital. Alisha refused to go so police determined to take her to <name of> hospital."*

She was admitted on a Form 1 (involuntary admission) at the hospital and discharged back to the residential program the next evening.

This next example of police involvement during an incident of self-harm was also reported as *Type #7: Complaint made by or about a client, or other serious occurrence involving a client*. This occurrence was reported by a children's mental health centre.

> *"At approximately 6:00 pm staff went to check on Nadia as safety plan outlines frequent check-ins. Staff did not find her in her bedroom, and did a quick search of the residence, and then found her in her closet, when they noticed a blood soaked towel peeking out from under the door. Staff unlocked the closet, Nadia told staff to 'go away,' and Nadia was found sitting in her closet with a rope tied tightly around her neck and observed several bleeding, self-inflicted wounds on the inside of her left forearm. The Acting building supervisor and on-call were informed, and it was agreed that police assistance would be request[ed] to support and assist in the situation. PC A and PC B arrived on the scene at approximately 6:20. PC A took the lead in attempting to verbally assist Nadia in removing the rope from around her neck, but Nadia continued to apply increased pressure to the rope. PC A and PC B dragged her out of her closet by her ankles. PC A used an instrument to cut the rope loose. While attempting to cut the rope, Nadia was using significant force to resist officers and was eventually placed in ankle shackles in order to prevent her from kicking the officers. EMS determined that Nadia would require pharmaceutical sedation as she continued to be resistant and non-compliant, and her current medications were reviewed with them. Additional officers and EMS workers arrived at <name of residence> (6 officers and 5 EMS workers in total were present on the scene). Nadia was injected with the sedating medication by an EMS worker and was subsequently hooked up to a blood pressure/ heart rate monitor prior to being strapped into the 'Stair Chair' and carried down to the main floor. Once straps were removed from 'Stair Chair,' she once again began to resist and struggle with the officers, and was placed onto the gurney and once again restrained by the officers until they were able to strap her down using the belts attached, as well as other sheets and first aid triangles to further ensure her safety."*

The child was transported by police and EMS to the hospital and admitted on a Form 1. Two days later, she was discharged into her mother's care and returned to the children's mental health residence.

MECHANICAL RESTRAINT

In 21 SORs, young people were confined in handcuffs by the police. In seven of these situations, the young person was known to have or suspected of having developmental disability. These were reported in six of the SORs as *Type #7: Complaint made by or about a client, or other serious occurrence involving a client* and one as *Type #2: Serious Injury*. The remaining 14 SORs involving handcuffs described use by police and reportedly in the context of a physical restraint. The use of leg shackles described in the case example given earlier is the only report of such use.

MECHANICAL RESTRAINT

	#
Young person handcuffed	21

YOUNG PEOPLE CALLING THE POLICE

In 15 SORs, it was the young person who contacted the police for assistance. (Several reports indicate that community members also contacted the police, but this was not specifically counted for this analysis).

Young person contacted police	15

In this next case example, the police were called by a peer concerned for another resident.

> *"Julie was not taking direction to join the group for dinner. She was given a choice of taking a few minutes to calm herself on her own or talk things through with staff. She ran to the living room and began ripping up cards and throwing pillows. She then ran to the kitchen and grabbed a container with food in it and threw it at staff, hitting them. She then grabbed a pen off the counter and made stabbing motions with the pen toward the staff. Staff used a minimum escort to contain Julie's safely. They escorted her to a quiet place on the stairs and sat with her. A second client came into the hallway and began hitting one of the CYWs holding on to Julie, demanding they let her go. Two staff came in from the kitchen and escorted the second client away from the area. Staff asked Julie to regulate her breathing to try to calm down. Julie escalated and a level one down containment was employed to manage her safely. The second client began yelling at staff to leave Julie alone, at the same time grabbed the phone and quickly dialed 911. An officer arrived within minutes. The officer's presence calmed everything down and the officer gave direction to Julie to clean up her mess and she was able to follow through."*

DISABILITY AND POLICE CONTACT

In 197 of SORs where police are involved, the young person is identified as having or suspected of having a disability. This means that a child with a disability is involved in at least 12% of calls to the police, with a majority having an intellectual, developmental or communication disability. The next chart identifies the occurrence type where police were called to a children's residence in a situation involving a young person with a disability.

POLICE, RESTRAINT AND DISABILITY

The police were called in relation to the restraint of a young person with a disability in 62 SORs (31%). The police escorted the young person to the hospital in 17 of these occurrences. The individual was charged in two instances and cautioned in 23 of the reports. In six of the reports, the police placed the young person in handcuffs.

The number of times that the police were contacted regarding self-harming behaviour among young people with developmental disabilities is presented in the table on the right.

The police were contacted for assistance in 15% of the SORs that describe self-harm behaviours by young people with or suspected of having a developmental or intellectual disability.

OCCURRENCE TYPE INVOLVING A YOUNG PERSON WITH A DISABILITY

OCCURRENCE TYPE	#	%
1. Death of a client	1	<1
2. Serious injury to a client	6	3
3. Alleged, witnessed, suspected abuse	2	<1
4. Missing person	62	31
5. Disaster on the premises	3	2
6. Complaint about the operational, physical or safety standards	4	2
7. Complaint made by or about a client, or other serious occurrence involving a client	57	29
8. Physical restraint of a client	62	31
TOTAL	**197**	-

SELF-HARMING BEHAVIOURS, POLICE CONTACT AND DEVELOPMENTAL DISABILITIES

DEVELOPMENTAL DISABILITY AND POLICE CONTACT	#
Developmental Disability: Yes	22
Developmental Disability: Unsure	8

DISCUSSION ON THE INVOLVEMENT OF POLICE WITH CHILDREN'S RESIDENCES

Slightly more than a third of all SORs (36%) reflect police involvement. When the police are called, in half of the SORs, it is to report a missing young person. Medical or mental crises account for 24% of police calls. Young people with disabilities are involved in 12% (n=197) of SORs describing contact with the police. Of these, almost a third (n=62) of these are calls for police assistance in situations that involve a physical restraint.

However, these are only records of police contact in the context of a serious occurrence and not necessarily an accurate accounting of every police interaction with program staff or young people in the residence. In order to obtain a true picture of police attendance at children's residences, the regulations could require an SOR to be filed every time there is police contact in order to capture all instances of police involvement. Alternatively, MCYS could obtain and track information about the number and nature of requests for police assistance by the residential service provider ("calls for service"), and also to track police attendance in situations where staff contact individual officers directly without going through the police switchboard.

The role of police in children's residences requires a province-wide discussion. The Ministry, police services and residential service providers should work collaboratively to gather data that more accurately reports the true rate of police attendance at children's residences and to ensure that the current pattern of engagement is consistent with the intention of legislation (*Youth Criminal Justice Act*, *Child and Family Services Act*, *Child, Youth and Family Services Act, 2017*), and best practice approaches.

High levels of police engagement at a particular residence could indicate that a child was inappropriately placed, that the home relies on police to deal with situations that should be managed internally, or that, given the circumstances, the agency has properly involved the police.

Within the context of this review, which indicates that most police interactions relate to dealing with a missing person or responding to medical/mental health crises, it may be worthwhile to consider whether these scenarios are the most appropriate use of police resources, and what, if anything, this finding suggests about the current configuration of the residential services system (including resource allocation) and children's mental health system.

6. VULNERABLE CHILDREN WHO GO "MISSING"

As noted in the preliminary report on serious occurrences, the research team met with service providers to discuss the SOR process and the research. In these consultations, service providers identified concerns about the police response to missing young people. One of the issues raised was the apparent unwillingness of certain police services to accept missing person reports related to young people living in children's residences. For example, service providers recounted being told by one police service that a missing person report can only be filed with the police service where the young person was **last seen** at the time that they went missing, and another police service only accepting missing person reports about young people who regularly **reside** in their jurisdiction. Similar barriers have been documented in other Canadian jurisdictions.[41] The Advocate's Office has also heard directly from police services with respect to missing person reports and young people in care. Their primary concern relates to residential service providers who submit missing person reports about young people whose whereabouts are known and therefore not missing, but away from the residence without permission. Police officials questioned whether there was a need for police involvement in these types of situations. Young people have raised concerns similar to those of the police with the Advocate's Office and also reported that they are rarely asked by workers or other service providers why they left, what happened to them while they were away, and what might prevent them from leaving again.

The *SOR Guidelines* restate CFSA Regulation 70/90, Section 102(2) for the reporting requirements:

> *SORs/ESORs may include clients missing for less than the prescribed ministry requirement where their absence is considered serious by the service provider. A child in the care of a CAS or a residential program who has been missing for 24 hours or more must be reported to the police, and the ministry if appropriate.*
>
> *All SORs/ESORs should describe whether the client poses a serious risk to themselves or others, any attempts made to locate the client, prior client history of leaving without permission, client's state of mind before leaving, precipitating events, etc.*
>
> *The service provider must advise the ministry once the client has returned, regardless of the date/time, via telephone or email message.*

NUMBER OF SOR TYPES

There was a final tally of 798 SORs referring to missing young people. This number was reduced from the earlier number of 944 reported in the preliminary report by matching the duplicates. In fact, most of the duplicate SORs received were related to *Type #4. Missing Person*, typically including an *Initial Report* followed by an *Inquiry Report*. Again, the redaction of these SORs made finding duplicates within this type more difficult than in any other category. Most reports were submitted within 24 hours, and most indicated the return of the young person on the *Initial Report*.

#4. Missing Person	798

In 28 of these reports, a statement is made that the bed was closed and the young person was not expected to return. In 146 (18%) of the missing person SORs, the location of the young person was not known as of the last report. Keep in mind that reports submitted after the March 31st sampling date would not be included and the absence of these reports does not mean that the young person remained missing. Of the 146 with the location not known, two of them had been missing for more than five days.

41 Welch, E. (2012). *Practices and Procedures in the Investigation of Missing Persons Across Canada: 1997 to present, A report prepared for the Missing Women Commission Injury* (British Columbia).

There were 798 SORs related to *Type #4: Missing Person*. In the majority (72%) of the occurrences, the SOR noted that the young person returned to the residence (n=574). Sometimes it was stated that the child returned on the same day (n=120). In the other reports, it was noted that the child returned to the residence but it is not clear how long they were gone. It was only possible to determine the exact length of time the young person had been missing in only 29% or 233 of the reports.

In 71% of these reports, the amount of time the young person was away from the residence was not recorded.

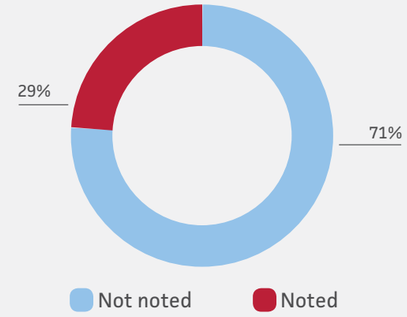
In half of the reports where the time is recorded, young people returned to the program the same day.

This next SOR reported on a Crown Ward who went missing.

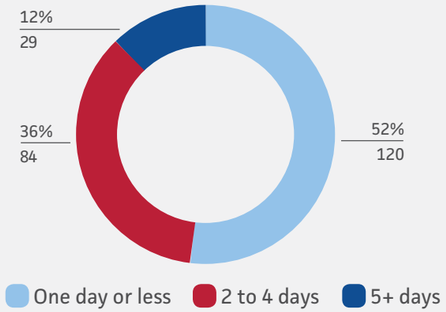
> *"On <date> he did not return to the residence from work at <employer>. He contacted the residence at approximately 11:00pm and explained that he would not be returning as he was hanging out with friends. As of <next day > he had not returned and subsequently his AWOL became a serious occurrence. He is not considered a high risk youth. He returned to the residence on <next day> at 2:00pm. He explained that he was with a friend but would not provide details as to who the friend was."*

The young person left again the next day, returning again to the residence. In both instances the staff submitted a missing person report to the police.

TIME AWAY FROM RESIDENCE REPORTED



LENGTH OF TIME MISSING WHEN NOTED



While some young people are late to return, or simply out for the night, other young people missing from residence are at extreme risk. In 37 SORs, there was an indication, by either a statement of such or by inclusion of a high risk form, that the young person was at high risk. As reported earlier, this analysis observed six sexual assaults that occurred while the young person was missing from a residence. Numerous reports describe young people who are found with adults in risky situations. In one of these reports, a "child in care" was found being exploited in the sex trade and found with a "pimp." Consider this next situation of sexual assault that occurred while the young person was missing from the residence.

> *"Hannah went AWOL from her group home. She was gone several hours. Staff received telephone call from [location] police stating that she had been located, and she was being taken to [location] hospital. At hospital, she disclosed that she had been sexually assault[ed] by, [redacted] that she met at Tim Horton's on [location] street. She had gone to the man's house, and she said that they had non-consensual [sic] sex. A rape kit was completed at [name] hospital in [location], and she was discharged back to her group home."*

In only 82 of the 798 missing person reports was there a narrative indicating that the young person was asked why they had left.

In just under half of responses that describe why the young person left, it was reported that they were out visiting friends. In 16 of these reports, the young person refused to say where they had been—including situations where the young person had been found in a risky situation. In five reports, the young person had left the residence because they were distressed, in two reports, it was over concerns such as peer conflict at the residence and in nine reports, they had left because they did not want to live at the residence. In 10 of the reports, the young person left to visit a family member.

In 29 of the reports, medical care was sought when the young person returned and in eight, the young person was offered medical care but they refused.

Mental health concerns account for 40% of the reports of seeking medical care after a young person returned from being missing. In four reports, medical care was sought to document a criminal act perpetrated against the young person.

The term "AWOL" (which we assume refers to being absent without leave) appears in 362 of the SORs and this language appears to be in common use.

REASONS WHY THE YOUNG PERSON LEFT

REASON FOR LEAVING	#
Concerns at residence	2
Don't want to be at residence	9
Visiting friends	40
Distressed or upset	5
Visiting family	10
Refused to say	16
TOTAL	**82**

REASON MEDICAL ATTENTION WAS SOUGHT

REASON FOR SEEKING MEDICAL CARE	#
Mental health	11
Physical health	6
Document criminal victimization	4
Refused	8
TOTAL	**29**

DISCUSSION ON MISSING CHILDREN

There were 798 SORs related to missing children. A large proportion of the police involvement at children's residences occurred in the context of missing person reports. Just under half (49%) of these police calls are to notify of a young person who has gone missing and the outcome of more than half (56%) is the filing of a report.

As noted earlier in the section on missing persons, this review finds that there appears to be three different profiles of young people who are missing. It is clear that in a majority of the missing person reports, the young person was either "late" returning or "out" for the night. Others were missing because they did not wish to return to the residence; however, it is significant that some young people in care are at extremely high risk when missing and the reporting and follow up in these cases often appears to be incomplete. Reports of sexual assault and exploitation, assault and exposure to risky situations all point to the need to find ways to safeguard missing young people who are extremely vulnerable due to either disability or history of trauma. At the same time, the challenge is to reduce exposure to the criminal justice system for young people whose whereabouts are known (although they may be absent without permission) while engaging the police proactively to safeguard those who are most at risk. The phrase AWOL, borrowed from the military, (meaning absent without leave), is used to describe all three of these profiles. The use of this terminology for all types of missing persons has the structural effect of masking the differing reasons for absence, and the differential nature of the risks to young people who are missing.

There is a need for policy development to support police and service providers in assessing the degree of risk to the young persons who are missing from their children's residence. Policy and legislative work done in British Columbia regarding the issue of missing persons can provide some guidance. The regulations to British Columbia's *Missing Person Act* require police officers to consider the following factors when assessing the potential risks to people who have gone missing:[42]

- **A.** may be likely to provide sexual services for consideration,
- **B.** may have been hitchhiking when the missing person went missing,
- **C.** may be likely to self-harm,
- **D.** may have a substance abuse problem,
- **E.** may require medication, or
- **F.** may not be prepared to deal with the weather at or the terrain of the location where the missing person may have gone missing.

In the Ontario context, the *Serious Occurrence Report* form could be revised to include a simple assessment of risk for young people who are missing. For example, the following indicators, adapted from the BC regulations to include the findings from this report, could be assessed in each situation, e.g.:

- **A.** may be likely to be exploited and sexually victimized,
- **B.** may have been hitchhiking (e.g. boat, car) when the missing person went missing,
- **C.** may be placed at risk due to likelihood of self-harm,
- **D.** may be placed at risk due to a substance abuse problem,
- **E.** requires medication within a set period of time,
- **F.** may not be prepared to deal with the weather at or the terrain of the location where the missing person may have gone missing,
- **G.** may be placed at risk due to intellectual or communication or developmental disability,
- **H.** is from a remote community and may be vulnerable due to their geographic isolation from family and community,
- **I.** may be at risk for other known or suspected reasons, or
- **J.** other unique circumstances surrounding their absence.

These indicators could be identified by simply checking a box on a newly revised SOR form. Service providers could also be required to give a brief summary to justify perceived risks. It is important to emphasize that any one indicator of risk does not mean that the young person is in fact at high-risk, but these do provide a method of assessing the degree of risk.

There is a need for a broadly based discussion within the field, including with emergency service personnel, about the appropriate response to various identified types of missing children. In 72% of the reports, the young person returned within 24 hours. Rarely (n=82) was there any indication that the young person was asked why they left, what had happened to them while they were away, and what might prevent them from running away again. The voice of the young person is almost completely missing from these reports and information about why the child left and their well-being is crucial information that should be recorded.

42 BC Reg 111/2015, s.3(2).

7. SELF-HARM

This section delves more deeply into the findings in this review that 40% of the SORs on serious injury examined by the researchers contained descriptors of young people who self-harm. Under the umbrella of self-harm, there are two distinct types of behaviours: Deliberate Self-Harm and Self-Injurious Behaviours.

Deliberate Self-Harming (DSH) (also known as NSSI[43] or non-suicidal self-injury) behaviours are thought to have some prevalence among the general population of young people in western societies.[44,45] There is emerging research that examines the prevalence of DSH in youth in residential care. One Canadian study found that about 35% of the 284 children aged 5-17 living in residential treatment programs[46] were in this category.

"THREATENED TO JUMP OUT OF THE WINDOW"

"CONSUMED LIQUID DETANGLER" *"poked himself in the neck several times with thumb tacks"*

"LAY ON THE FLOOR BANGING HIS HEAD" **"SWALLOWED SOME THUMB TACKS"**

"INGESTED 100 TYLENOL PILLS"

"found a pair of leggings, tied around her neck and the other end tied to the door knob"

"SAID NOTHING CAN EXPLAIN HOW I FEEL UNLESS I CUT"

"BITING AND HITTING HIMSELF"

There is also a phenomenon known as SIBs (Self-Injurious Behaviours) prevalent among a segment of people with developmental disabilities. The reasons for this remain unclear; however, some studies have found that SIBs can be an expression of physical pain or it can be a learned behaviour.[47] The finding that pain may induce SIBs goes against commonly held, but untested beliefs that individuals engaging in SIBs do not experience pain.[48] It is important to note that the frequency and intensity of SIBs can result in serious injury and the persistent nature of these behaviours can make these very harmful. SIBs include repetitive finger biting, head hitting, lip licking and chewing as just some examples. They are persistent and seem to escalate with age. Some syndromes — such as Lesch-Nyhan, Cornelia del Lange, Cri du Chat, fragile X, Prader-Willi and Smith-Magrenis — are associated with SIBs. The degree of intellectual disability may also increase the likelihood of SIBs.[49]

43 Favazza, A.R. (2012). "Nonsuicidal self-injury: How categorization guides treatment." *Current Psychiatry*. 11(3), 21-26.

44 Heerde, J.A., Toumbourou, J.W., Hemphill, S.A., Herrenkohl, T.I., Patton, G.C. and Catalano, R.F. (2015). Incidence and course of adolescent deliberate self-harm in Victoria, Australia, and Washington State. *Journal of Adolescent Health*, 57, 537-544.; Perry, I., Corcoran, P., Fitzgerald, P., Keeley, H., Reulbach, U., and E. Arensman (2012). The incidence and repetition of hospital-treated deliberate self-harm: findings from the world's first national registry. *PloS One*, 7(2), e31663.

45 Heerde, J., Toumborurou, J., Hemphill, S., Herrenkohl, T., Patton, G., and R. Catalano (2015). Incidence and course of adolescent deliberate self-harm in Victoria, Australia and Washington State. Journal of Adolescent Health, 57, 537-544.

46 Stewart, S., Baiden,P., Theall-Honey, L., and W. den Dunnen (2013). Deliberate self-harm among children in tertiary care residential treatment: prevalence and correlates. Child and Youth Care Forum, 43:63-81.

47 Symons. F., Harper, V., McGrath, P., Breau, L., and J. Bodfish, J. (2009). *Evidence of increased non-verbal behavioural signs of pain in adults with neurodevelopmental disorders and chronic self-injury Research in Developmental Disabilities*, 30, 521-528.

48 Symons, F., ElGhazi, I., Reilly, B., Barney, C., Hanson, L., Panoskaltsis-Mortari, A, Armitage, I., and Wilcox, G. (2015). Can biomarkers differentiate pain and no pain subgroups of nonverbal children with cerebral palsy? A preliminary investigation based on non-invasive saliva sampling. Pain Medicine, 16: 249-256; Oliver, C & Richards, C. (2015). Practitioner review: self-injurious behaviour in children with developmental delay. *Journal of Child Psychology and Psychiatry*, 56:10, 1042-1054.

49 Oliver, C. & Richards, C. (2015). Practitioner review: self-injurious behaviour in children with developmental delay. *Journal of Child Psychology and Psychiatry*, 56:10, 1042-1054.

SELF-HARMING BY TYPE OF OCCURRENCE

The table on the right presents the type of occurrence reported when self-harming was mentioned in the narrative report.

Our review of the sample of SORs identified 641 reports of self-harming behaviours, representing 14% of all SORs submitted. There were 158 SORs that indicate that the young person threatened to seriously harm themselves. In 47 occurrences, the young person placed themselves in immediate danger such as running into a busy road or highway. In 13 occurrences, young people ingested noxious substances such as Windex or nail polish remover.

The second table on the right shows the sex of the young person engaged in self-harming behaviours.

Just over half of the SORs, related to self-harming behaviour concerned girls and 42% were about boys. In 4% of the SORs, the gender was written using gender neutral language or redacted.

DISTINGUISHING SELF-HARMING AND SUICIDAL BEHAVIOURS

A distinction was made when coding between deliberate self-harm and suicidality. The research team created these categories as the SOR does not differentiate the types of self-harm. This next incident provides an excellent example of a skilled child and youth care practitioner effectively defusing a situation and helping a young person process their complex and overwhelming emotions. It happens in a children's mental health centre. Earlier the girl had also swallowed hair conditioner and staff note that they checked with poison control for toxicity.

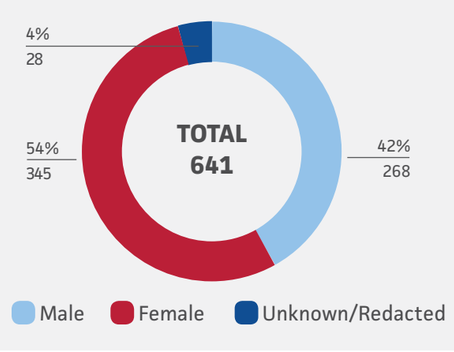
> *"Staff A announced herself before entering client Natasha's bedroom. Upon entering staff A saw client Natasha sitting on the bed with a belt around her neck, client Natasha was pulling both sides of the belt. Client Natasha informed staff A that she [w]as strangling herself in an attempt to kill herself. Client Natasha asked staff A to leave the room so she could continue. Staff A informed client Natasha that she was unable to do so. Client Natasha started to cry and talk about her desire to end her life. Staff A was able to calm down client Natasha through conversation. Client Natasha request to talk to her father and staff B. Staff A accompanied client Natasha to the washroom as she wished to wash her face. Staff A escorted client Natasha [to] the extension to have a phone call with father and a conversation with staff B."*

The report narrates that the young person continues to express a desire to die and the staff and young person together make a plan for a referral to an inpatient program and the occurrence resolves.

SELF-HARM BY TYPE OF OCCURRENCE

OCCURRENCE TYPE	#
1. Death of a client	0
2. Serious injury to a client	77
3. Alleged, witnessed, suspected abuse	0
4. Missing person	16
5. Disaster on the premises	0
6. Complaint about the operational, physical or safety standards	0
7. Complaint made by or about a client, or other serious occurrence involving a client	93
8. Physical restraint of a client	455
TOTAL	**641**

SEX OF CHILD SELF-HARMING



As a contrast to the previous narrative, identified as suicidal behaviour, this next example was classified as non-suicidal self-harm.

> *"Falisha refused her night time medication as she told the staff that she was planning to stay up for 3 nights. At bedtime she started to yell and bang around her room. Staff A managed the environment by staying by her doorway. Staff A asked how she received scratches on her face and neck. Falisha told her that she had Bobbi pins in her underwear and she used one to scratch herself. Staff A asked her to hand them into her but she refused. Falisha then proceeded to the corner of her room and grabbed a Bobbi pin from out of her underwear and right away put it in her mouth. Falisha said she was going to slice the top [of] her mouth as she wanted to see blood. Falisha was placed in a sitting position of control for her safety. Staff A controlled her left arm and Staff B controlled her right. This writer counseled [sic] with her to spit it out and Falisha spat it out. After approximately 10 min when calm, Falisha was released. Falisha required staff to stay in close proximity by sitting on her floor while she lies on her bed as she still has Bobbi pins in her underwear..."*

This occurrence ends with the young person falling asleep while the staff person sits on the floor to prevent further use of the Bobbi pins to self-harm.

The self-harming behaviours reported in these SORs ranged in degree of potential harm from swallowing objects and noxious substances, to running into busy road traffic, to attempting to exit a moving vehicle as well as, cutting, banging, biting and other such behaviours.

SELF-HARMING BEHAVIOURS

Oftentimes, more than one self-harming behaviour was documented within an SOR. The predominant behaviour described in SORs reporting self-harming behaviours are as follows.

The SORs detail numerous examples of self-harming behaviour. While most of the behaviours were superficial, other situations resulted in potentially very high risk situations. There are examples of young people running into busy road traffic, attempting to climb onto roofs and attempting to exit moving vehicles. While only 68 SORs specifically refer to SIBs, another 133 examples describe young people banging a part of their body repeatedly or biting themselves that could possibly be SIBS. In 29 reports, the youths tried to choke or hang themselves and in 14 reports, the taking of excessive medication while a further 13 reported that the young person ingested an object or a noxious substance.

SELF-HARMING BEHAVIOURS

BEHAVIOURS	#
Threaten to seriously harm self	158
Cut self	122
Hit self or something	53
Bite self (could be SIBs)	22
Bang part of body (could be SIBs)	111
Take excessive medication	14
Attempt to choke or hang self	29
Ingest substance or object	13
SIBS	68
Place self at extreme risk (in middle of highway, trying to jump off roof or bridge)	47
Rub self	4

SUICIDAL THREATS AND ACTIONS

There were 175 SORs that described suicidal actions by young people, reported by these types of occurrences.

Most of the reports that indicate suicidal behaviours were reported as *Type #7 Complaint made by or about a client, or other serious occurrence involving a client*. Serious suicidal actions are reported in four types of occurrences and it is necessary to examine all four types to get the total number of SORs related to these. In four SORs, a suicidal young person was missing and in each case the police were notified. In all of these cases, the young person returned to the program. Combining all reports of self-harming or suicidal behaviours, there were 734 reports of threats of self-harming or suicidal behaviours in the three-month period covered in this review.

SUICIDAL ACTIONS

OCCURRENCE TYPE REPORTING SUICIDAL ACTIONS	#	%
#2 Serious injury to a client	34	19
#4 Missing person	4	2
#7 Complaint made by or about a client, on other serious occurrence involving a client	109	62
#8 Restraint of a client	28	16
TOTAL	**175**	*

* Exceeds 100 due to rounding

EMERGENCY SERVICES, HOSPITALIZATION AND SELF-HARM

The Canadian study mentioned earlier noted steadily increasing rates of visits to Emergency Departments by young people aged 20 to 24 year for reasons related to mental health and addictions.[50] In the three-month period under review, there were 167 requests for medical attention documented in relations to reports of self-harming behaviours. There were 147 visits to the Emergency Department and the young person was held involuntarily in the mental health unit under a Form 1 committal under the *Mental Health Act* in 35 of these occurrences.

The table on the right examines the involvement of emergency services (police, fire, ambulance) for self-harming or suicidal behaviours.

In 28% of SORs where there was mention of threats of self-harm or self-harming behaviours, the police or ambulance was called. In 20% of these reports, the young person was transported to the Emergency Department at a local hospital.

SELF-INJURY, SUICIDAL BEHAVIOURS AND EMERGENCY SERVICES

SERVICE TYPE	#	%
Police, ambulance	206	29
Emergency Department	147	20

SELF-INJURIOUS BEHAVIOURS (SIBS)

It is believed that there are multiple causes of SIBs. Some SIBs might be learned behaviour, while in other cases it could signal an undiagnosed medical condition that is causing pain or distress.[51]

The second table on the right shows the number of SORs that describe self-harming behaviour by a young person known to have or suspected of having a developmental or intellectual disability.

In this reporting period, 27% of the SORs were about young people identified as having a developmental disability who engaged in self-harm behaviours.

SELF-HARMING BEHAVIOURS BY THOSE WITH OR SUSPECTED OF HAVING A DEVELOPMENTAL DISORDER

DEVELOPMENTAL DISABILITY	#
Yes	131
Unsure	65

50 Gandhi et al., (2016). "Mental health service use among children and youth in Ontario: population-based trends over time." *The Canadian Journal of Psychiatry*, 61(2), 119-124.

51 Winter, C., Jansen, A. and H. Evenhuis (2011). Physical conditions and challenging behaviour in people with intellectual disability: a systematic review. *Journal of Intellectual Disability Research*, 57(7):675-698.

SENSORY ROOMS AND ASSISTIVE DEVICES

There were some SORs that made reference to a calming room. It is not clear if these are some form of Snoezelen Room that allows young people to calm and self-regulate the degree of stimulation they receive. These controlled, multi-sensory environments allow the young person to redirect sensations through stimulating aspects and to be soothed and to self-soothe with the shapes, textures and sounds available there. There is some evidence that in these environments, individuals with developmental disabilities reduce aggression and SIBs, although more systematic study is needed to understand the impacts of these environments and the ongoing duration of these impacts after use.[52,53]

DISCUSSION ON SIBS AND DSH IN CHILDREN'S RESIDENCES

DSH

Deliberate self-harm is known to have some prevalence in the general youth population and there is some research examining the rates for those in out-of-home care.[54] Looking at Ontario data and also directly related to this population, Grenville, Goodman and Macpherson[55] examined SORs about the deliberate self-harm (DSH) by 252 youth in care of the Children's Aid Society of Toronto. The study found DSH "more prevalent among 14-21 year olds than 6-13 year olds." It is interesting to note that most of the incidents that their study reviewed occurred "between 6pm and 12am Monday to Friday." They also found that females were "more likely to have repeat DSH incidents."

The self-harming behaviours ranged in degree of risk from superficial cutting to placing oneself at extreme risk, e.g. running out into road traffic or exiting a moving vehicle. Suicidal actions were reported at a rate of almost two incidents per day during the review period. There were 95 visits to the Emergency Department and in 20 situations, the youth were involuntarily admitted to the psychiatric unit at the hospital.

In 79% of SORs, a child welfare agency is involved with the child. This finding suggests that the population in this study is likely to have experienced some form of child maltreatment resulting in symptoms of trauma. Considerable evidence exists linking self-harm to the long-term impacts of trauma and neglect.

There are thought to be many reasons behind DSH, with associations made to child maltreatment, chronic physical pain and relief of overwhelming emotions. Approaches to trauma-informed care consider DSH and aggressive acting out as Emotional-Pain-Based-Behaviours (EPBB). Such behaviours emerge when the young person lacks the developmental capacity to process the complex emotions related to trauma.

RELATIONAL CARE

Front line staff have the opportunity to play an essential role in fostering and nurturing the capacity of young people for human connectedness and recovery from trauma. Bessel Van Der Kolk, a Professor, Psychiatrist, and noted expert on trauma explored an interesting insight he gained treating adult patients who self-harm:

"I concluded that, if you carry a memory of having felt safe with somebody long ago, the traces of that earlier affection can be reactivated in attuned relationships when you are an adult, whether these occur in daily life or in good therapy. However, if you lack a deep memory of feeling loved and safe, the receptors in the brain that respond to human kindness simply fail to develop. If that is the case, how can people learn to calm themselves down and feel grounded in their bodies?"

The skilled practitioner, by creating a caring relational bond that preserves the young person's dignity and bolsters their capacity, can assist the young person in regaining self-control and managing overwhelming impulses. Equipping the young person with alternative strategies can be done by coming to understand the young person's feelings and perceptions in order to be able to guide and support the young person as they learn to self-regulate their behaviour and emotions. Emotionally assisting the young person in a caring, predictable and developmentally appropriate manner triggers the neuroplastic capacity of the brain (its ability to recover from injury or underdevelopment) to establish or reconnect the receptors that respond to attachment and care-giving behaviours.[56,57]

SIBS

Deliberate self-harming behaviours were found, in this review, to be more common than suicidal behaviours and occurred at a rate of eight per day. This rate would appear to be consistent with the prevalence rates reported in the research about adults with developmental disabilities.[58] It is interesting to note that there were very few instances where agencies reported the use of helmets, padding or other instruments that could reduce the impacts of SIBs.

Estimates are that the prevalence of SIBs in the general population of individuals with developmental or intellectual disabilities range from 4 to 24%.[59] Generally, SIBs behaviour is underreported, as it is often described as self-harm rather than SIBs-like behaviour. Contradicting the myth that young people with developmental disabilities do not experience pain, research has explored the degree of force used when engaging in SIBs. A kinematic analysis of force applied from SIBs-like behaviour such as head banging estimates that "impact forces combined with the frequency of blows are the equivalent of dropping a 48 oz (3 lb) hammer on your head every second for up to half an hour."[60]

The prevalence of SIBs is likely underestimated in this current analysis due to a lack of specific and descriptive language for the behaviours in the SORs. For example, a report that indicates that the young person "was self banging her head" gives insufficient information to know the etiology of the behaviours. Why was the young person banging her head? What was she banging her head against? What degree of force was used? How many times did she bang her head? Was this something repetitive that had a safety plan or was this a one-time isolated event? Simply stating that the child is self-harming does not describe the level of risk. A young person banging their head on a pillow while lying in bed (reported in an SOR) described as head banging is not at the same risk as a young person repetitively hitting her head against concrete causing her to bleed.

SUMMARY

In summary, 40% of SORs about serious injury involved young people who had harmed themselves. Deliberate self-harming behaviours were found, in this review, to be more common than suicidal behaviours, occurring at a rate of eight per day. Twenty-seven per cent of SORs about young people engaged in self-harm were about young people with a disability. As well, there is very little information contained in the SORs about injury prevention strategies. Given these findings, there may be a need to explore the extent to which protective equipment, environmental modification, and injury prevention strategies are considered and implemented with this population of young people. Further information about the overall capacity of the children's residential services sector to respond to incidents of suicidality, deliberate self-harm, and self-injurious behaviour is also something which must be considered.

52 Singh, N., Lancioni, G., Winton, A., Molina, E., Sage, M., Brown, S., Groeneweg, J. (2004). Effects of Snoezelen room, activities of daily living skills training, and vocational skills training on aggression and self-injury by adults with mental retardation and mental illness. *Research in Developmental Disabilities,* 25: 285-293.

53 McKee, S., Harris, G., Rice, M. and L. Silk (2007). "Effects of a Snoezelen room on the behaviour of three autistic clients." *Research in Development Disabilities,* 28: 304-316.

54 De Leo, D. & Heller, T.S. (2004). Who are the kids who self-harm? An Australian self-report school survey. *The Medical Journal of Australia*, 181(3), 140-144.

55 Grenville, J., Goodman, D., and Macpherson, A.K. (2012). Characteristics of self-harm behaviour among identified self-harming youth in care. *International Journal of Mental Health Addiction* 10:646-659.

56 Doidge, N. (2007). *The brain that changes itself: Stories of personal triumph from the frontiers of brain science.* New York: Viking.

57 Van Der Kolk, B. (2015). *The body keeps the score: brain, mind and body in the healing of trauma.* Penguin Books.

58 Arron, K., Oliver. C., Moss, J., Berg, K. and C. Burbidge (2010). "The prevalence and phenomenology of self-injurious and aggressive behaviour in genetic syndromes." *Journal of Intellectual Disability Research*, 55(2), 109-120.; Richards, C., Davies, L. and C. Oliver (2017). "Predictors of self-injurious behavior and self-restraint in Autism Spectrum Disorder: Towards a hypothesis of impaired behavioral control." *Journal of Autism and Developmental Disorders*, 47(3), 701-713.8

59 Oliver, C. & Richards. C. (2015). "Practitioner review: Self-injurious behaviour in children with developmental delay." *Journal of Child Psychology and Psychiatry*, 56(10): 1042-1054.

60 McComas, J. & Symons, F. (2013). "The motivation for self-injury: Looking backward to move forward." In Reed et al. (Eds). *Handbook of Crisis Intervention and Developmental Disabilities, Issues in Clinical Child Psychology.*

8. THE PHYSICAL RESTRAINT OF YOUNG PEOPLE

A total of 2,230 SORs were analyzed under category *Type #8: Restraint of a Client.* Reports about restraint were submitted by 105 of the 205 agencies who provided SORs to MCYS during the time period of this review. Twenty-five agencies reported 80% (1789) of the SORs relating to the use of physical restraint. The remaining 20% (441) of these submissions were reported by the other 80 agencies. At this submission rate, each day, MCYS receives 25 SORs about *Type #8: Restraint of a Client* in a children's residence in Ontario.

There is a distinction between physical engagement with young people and the physical restraint of young people. In the context of children, physical intervention might mean: holding a young person's hand, or touching their shoulder in order to cue them, or a hug. After all, we are discussing children and touch is an important expression of nurturance. Most parents know that physical prompting or what the CFSA regulations describe as brief and gentle is part of teaching a child to self-regulate behaviour.[61]

Physical restraint, on the other hand, is the physical control of the child's body, in order either to remove the child from the situation or to stop aggression towards others, self-harm or risk of imminent harm.

As mentioned previously, the physical restraint of children is governed by the CFSA regulations. CFSA Regulation 70 was amended in 2002 to provide further clarification by adding section 109.1, 109.2 and 109.3 that came into effect on April 1, 2003.

Section 109.1 (2) states:

Every licensee operating a residence shall ensure that physical restraint of residents of the residence is not carried out except in accordance with the following rules:

1. *Physical restraint of a resident may be carried out only,*

- **i.** *for the purpose of preventing the resident from physically injuring or further physically injuring himself or herself or others, or*
- **ii.** *[does not apply to this review]*

This review excludes young offender residences and therefore 1.ii does not apply. The only acceptable reason for a restraint in a licensed children's residence is imminent harm to self or others.

Subsection 109.1 (2). continues as follows:

2. *Physical restraint of a resident may never be carried out for the purpose of punishing the resident.*

3. *Physical restraint of a resident may be carried out only if there is a clear and imminent risk that,*

- **i.** *the resident will physically injure or further physically injure himself or herself or others, or*
- **ii.** *[does not apply to this review]*

4. *Physical restraint of a resident may be carried out only after it is determined that less intrusive interventions are or would be ineffective in,*

- **i.** *preventing the resident from physically injuring or further physically injuring himself or herself or others, or*
- **ii.** *[does not apply to this review]*

5. *Physical restraint of a resident may be carried out,*

- **i.** *by a member of the residence's staff, if he or she has obtained the training and education described in section 109.3, or*
- **ii.** *by the licensee, if the licensee is an individual who provides direct care to residents of the residence and has obtained the training and education described in section 103.3.*

61 RRO 1990, Reg 70, s 102.

6. *A particular holding technique may be carried out,*

- **i.** *by a member of the residence's staff, if he or she has received specific training in that technique in a training program approved by the Minister, or*
- **ii.** *by the licensee, if the licensee is an individual who provides direct care to residents of the residence and has received specific training in that technique in a training program approved by the Minister;*

7. *When physical restraint of a resident is carried out, it must be carried out using the least amount of force that is necessary to restrict the resident's ability to move freely.*

8. *During physical restraint of a resident, the resident's condition must be continually monitored and assessed.*

9. *Physical restraint of a resident must be stopped upon the earlier of the following:*

- **i.** *When there is no longer a clear and imminent risk that,*
  - **A.** *the resident will physically injure or further physically injure himself or herself or others, or*
  - **B.** *[does not apply to this review]*

In summary, in a licensed children's residence, the regulations permit the use of physical restraint only within the following nine rules.

1. To prevent harm, prevent the child from injuring themselves or others (s. 109.1(2) 1.)

2. Never for the purpose of punishment (s.109.1(2) 2.)

3. Only for clear and imminent risk (s. 109.1(2)3.)

4. Only after less intrusive measures have been tried or are not feasible (s. 109.1(2) 4.)

5. Only by trained staff (s. 109.1(2)5.)

6. Only using approved holding techniques (s. 109.1(2)6.)

7. Using the least amount of force necessary (s.109.1(2)7.)

8. Constant monitoring and reassessment during restraint (s. 109.1(2)8.)

9. Restraint is released as soon as imminent risk has stopped. (s. 109.1(2)9.)

There are seven basic points that need to be included in a *Serious Occurrence Report* on the use of physical restraint with children. An *Initial Notification Report* is to be submitted within 24 hours. A summary of the incident is captured in Section C and if more room is needed, additional pages can be attached. *Section C: Details of Serious Occurrence* includes a note to describe the following: "*What, where and when it happened, actions taken by the service agency.*" It goes on to specify that: "*For physical restraint reporting, please include: current status/condition, person's views/allegations, and service agency action.*"

Simply put, one way to think about this is that a complete report would provide the answers to the following questions.

- What circumstances led up to the incident?
- What was done to de-escalate the situation?
- What were the behaviours causing threat or harm?
- What approved restraint method was used, by whom and for how long?
- How was safety maintained and were there any concerns or injuries?
- Did debriefing occur with the young person/their perception of the incident?
- What other debriefing occurred?

The reports regarding *Type #8: Restraint of a Client* were examined to identify the data needed to answer the basic points required by the MCYS guidelines.[62]

62 Ministry of Community and Social Services/Ministry of Children and Youth Services (2013). *Serious and Enhanced Serious Occurrence Reporting Guidelines*

As noted earlier, a total of 3,599 restraints were reported during the review time period in 2,230 SORs. This indicates that in Ontario, every day, on average, 40 restraints are used in a children's residence, that is, a rate of one (1.7) restraint of a child each hour at a children's residence in Ontario during the period under review.

DOES SOR REPORTING COMPLY WITH THE SOR GUIDELINES?

Any use of physical restraint of a client in a residence licensed as a children's residence must be reported. The service provider must determine if the restraint resulted in: (a) no injury, (b) injury or (c) an allegation of abuse.

The requirements needed when reporting any restraint are outlined in the *Serious and Enhanced Serious Occurrence Reporting Guidelines* which state that the report must describe the following:[63]

- The type of restraint used
- Use of less intrusive intervention before the restraint
- Duration of the restraint
- Client and staff debriefing
- Legal status of the client
- Names of all parties notified and
- Whether the use of the restraint resulted in injury or an allegation of abuse (see also: CFSA Regulation 70).

In this review, each SOR was coded to try to determine which of the approved restraint techniques was used during the restraint. As discussed earlier, the Ministry of Children and Youth Services has approved six training methods. These are known and described in the SORs as CPI (the Crisis Prevention Institute); CTI (Canadian Training Institute); UMAB (Hy'N'Hancement Consulting Inc.); PMAB (Preventing and Managing Aggressive Behaviour Focus Group and Satori Learning Design Alternatives); TCI (Cornell University) and SMG (Safe Management Group). Each of these programs teach courses that include segments on self-defence and release (e.g. releasing from a bite), de-escalation strategies and a sequence of least-intrusive to full-control physical restraint.

The table to the right presents the type of restraint used when this information was documented, for the first reported incidence of a restraint.

The UMAB (Understanding and Managing Aggressive Behaviour) program is the most frequently identified method. Almost a quarter of the SORs (514) about restraint do not identify the method of restraint. Instead, the language used to describe the restraint was often quite vague, with comments using terms such as "*holding,*" "*hug hold,*" "*child restraint,*" "*contained*" and "*restrained*."

TYPE OF RESTRAINT METHOD IDENTIFIED

RESTRAINT METHOD	#	%
Understanding and Managing Aggressive Behaviour (UMAB)	640	29
Prevention and Management of Aggressive Behaviour (PMAB)	154	7
Safe Management Group (SMG)	266	12
Therapeutic Crisis Intervention (TCI)	271	12
Non-Violent Crisis Intervention/ Crisis Prevention Institute (NVCI/CPI)	384	17
Safety-Care: Behavioural Safety Training (QBC)	1	<1
Not Otherwise Specified	514	23
TOTAL	**2230**	*

* Exceeds 100 due to rounding

63 Ministry of Community and Social Services/Ministry of Children and Youth Services (2013). Serious and Enhanced Serious Occurrence Reporting Guidelines p.9.

USE OF LESS INTRUSIVE INTERVENTION BEFORE THE RESTRAINT?

It was very difficult to determine which less intrusive measures were used. To be fair, the *SOR Guidelines* do not go into detail regarding what should be included in this section. Very often the phrase "less intrusive measures were tried and failed" was the only descriptor of these attempts. Sometimes a list was provided and these were of varying quality. The following is an example of such a list that provides the reader with very little understanding about how the staff attempted to defuse the situation:

> *"Staff offer choices, gave cues, stated clear expectation, and used PMAB blocking and deflecting techniques"*

Statements such as this do not identify the choices that the young person was offered. The young person referred to in this report is nine years old. The narrative accompanying the above list begins with this description:

> *"Jeremy was asked to leave the area where other kids were playing because he was throwing toys at them. He then became physically aggressive by pushing and punching at staff. Staff intervened and escorted Jeremy away from the other children using a PMAB escort position. Jeremy was escorted to the hallway area where he was restrained in a stationary escort position for two minutes."*

Strategies — such as having the staff assume close proximity to the child and attempt to engage them with other toys or to provide a distraction meaningful to the child, or even engage them and support them in learning how to vent their anger — are rarely described. Such relational approaches may have de-escalated this situation. Identifying a child's specific motivator would have also been clearer, e.g. offering to engage with the child in a desired activity as a means of defusing and supporting the child in regaining emotional control. Following the escort to the hallway, the young person was then "released into his room" where he resumed throwing "toys and hard objects" and was subsequently restrained three more times. This does not describe a situation where a practitioner supports the child by helping them with their evolving capacity to self-regulate their emotions. It should be noted that some SORs did report such actions by the practitioners. Breathing routines and deep breathing exercises are most often mentioned.

Sometimes "less intrusive interventions attempted" are listed in the report as bullet points. Consider this next SOR that resulted in a physical escort and physical restraint.

> *"Jason was upset about a consequence for pushing staff. He began hitting himself in the head with a computer keyboard and wrapped a computer cord around his neck. When this writer attempted to remove these items from him he began punching her. Staff physically intervened and used a PMAB escort position to transport Jason out of the classroom, as space in the classroom did not allow for the safe use of a physical restraint if required. Once out of the hallway, Jason began kicking and pushing staff while in the escort position, staff maintained this position for about two minutes and then released. Jason began punching staff again and staff physically restrained using an escort position, staff then transitioned to a straight arm position. Jason was restrained for four minutes and released."*

The following is listed under the heading: Less Intrusive Interventions Attempted and Client Response:

> *"Clear direction, giving space, open questions, listening responses. X continued to attempt to harm himself and therefore [staff] physically intervened."*

It is difficult to reconcile the list provided at the end describing the less intrusive interventions to the narrative provided about the restraint. The description reads that the staff tried to remove the keyboard and cord from the young person. When the staff did this, the child began to hit the staff and then the staff physically restrained the child in an escort position. If one assumes that the staff directed the child to put down the keyboard and cord before trying to remove these items, it is reasonable to assume that is what was meant by clear direction. There is no mention of "giving space" such as perhaps backing away to allow the child to stop the self-harming behaviour before trying to remove the items. Open questions are

not mentioned nor are examples of listening responses. What is described is a child harming themselves, a staff perceiving this to be a threat to the child's safety and then choosing to remove the item, which ultimately escalated the situation to where the child began to punch the staff and the staff physically restrained the child. The point of this is not to evaluate the necessity of the restraint; rather it is to point out that the descriptions of the less intrusive interventions attempted could have been expanded on to provide the reader with a greater understanding of what was done to de-escalate the situation.

LENGTH OF TIME IN RESTRAINT

The table on the right provides the duration of the restraint (when recorded). These were classified as a) less than 10 minutes, b) 10 minutes to 59 minutes, c) one hour plus and d) not mentioned.

The length of time the child was restrained is not recorded in 19% of the SORs submitted under *Type #8 Restraint of a Client*. Restraints lasting between 10 minutes and 55 minutes comprise 45% of the restraints. Just under a third (29%) of the restraints have a duration of less than 10 minutes.

HOW LONG CHILD HELD IN THE RESTRAINT

TIME	#	%
Less than 10 minutes	656	29
10 minutes to 59 minutes	993	45
One hour plus	120	5
Redacted		<1
Not mentioned	413	19

THE ISSUE OF IMMINENT THREAT

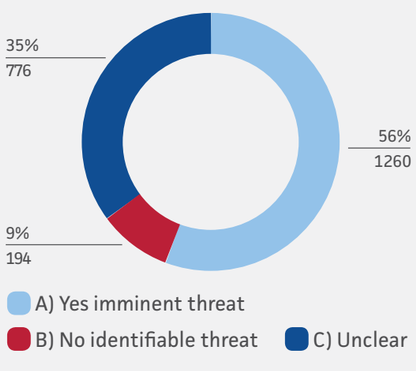
There is no question that in their day-to-day work, residential staff encounter considerable direct and indirect exposure to a range of aggressive actions. The SORs document situations, some lasting many hours, where young people are threatening, spitting, hitting, kicking and throwing objects. There is also documentation of considerable self-harm and property damage on the part of the young people. The test of "*imminent threat to self or others*" was seemingly met in a majority of the restraints recorded in the SORs that staff submitted after an incident.

The phrase "*extremely non-compliant and aggressive*" was repeatedly used and in some residential programs this phrase served as the most common descriptor used in the SORs from that location. Other examples include: "*aggressed towards staff*," "*very angry and out of control.*" Such phrasing tells the reader very little. Using stock phrasing does not assure the reader that the imminent threat criteria has been met in the context of a specific physical restraint used with a particular child.

When analyzing these reports, the researcher assumed the perspective of someone with university level critical thinking capacity, a good understanding of the CFSA, and an expert understanding of the *SOR Guidelines*. From this perspective, the researcher then, identified whether the threshold for physical force had been met. Each restraint was assessed to determine if there was a) an identifiable imminent threat, b) it was possible that there was a threat, but it was not clearly stated as such and c) there was no imminent threat identified.

This next table categorizes the assessment of the justification for use of physical restraint as documenting an identifiable threat preceding the restraint. When making this evaluation, SORs that clearly contained descriptions of actions that seemed threatening were classified as yes, to give the benefit of the doubt to the reporting agencies. Those with stock phrasing such as the "child made an aggressive motion towards staff," were classified as unsure even when a direct threat could not be identified. Any situation involving property damage alone, non-compliance with staff direction or without any indication of potential violence towards others were classified as no imminent threat.

THREAT IMMINENT



In 56% of reports, the imminent threat that presented legal grounds to utilize physical restraint was clearly apparent. In these SORs, the narrative was descriptive, e.g. the child punched the staff or he ran towards the staff with his fist raised. This next SOR provides descriptive language about the behaviour and includes clear efforts by staff to defuse the situation and debrief post restraint.

> *"Liam had been asked to prepare for his bedtime routine. He became angry and began targeting his peer. While walking through the hallway he attempted to throw a laundry basket at a peer who was on the phone. Staff allowed space before speaking with him. While staff were waiting to speak with him he started throwing various objects at his window as well as trying to break it several times with his hands. He also threw several items off his bed at this writer. Staff intervened and attempted to move him away from his window. Each time he would become more physically aggressive towards staff by raising [his] fist in a striking motion. He then charged at staff A attempting to push her. As he had struck staff A and shown physical aggression, he was briefly held in a standing restraint although he continued to struggle and kick and was then lowered to a prone position. He stated he did not want to be held. He was no longer being physical and was released. Shortly after he started to scream, yell and curse. He was then escorted to another room where he could no longer be disruptive. He was released and then spoke with staff. Staff will continue to assist him through this difficult time. Total restraint time was five minutes. He was able to speak with this writer and explained that he doesn't know what is wrong with him and he doesn't want to be angry and wants help. This writer assured him that we are helping him and have no plans on stopping. The writer offered several suggestions to help like speaking with staff, mom or his clinician. He said he would like to journal. The writer agreed that would be a good idea. This writer and Liam discussed the dangers of becoming aggressive and what it could lead to. He then had a drink and departed to bed."*

In 35% of the SORs, it was difficult to determine the precise nature of the threat and whether it was imminent. These SORs included narrative that was vague, only noting, for example, that the child became aggressive or that he made aggressive motions. These descriptors make it difficult to determine the imminent threat.

The researcher noted that sometimes the descriptor was so vague that it was difficult to understand what the behaviours were being exhibited. Below is an example of one such report.

> *"Client began to aggress towards staff and the environment."*

This next example of an SOR was handwritten and the following paragraph contains the whole description provided about the event.

> *"Calvin became extremely non-compliant & aggressive towards staff & property. After several attempts to redirect Calvin with no success a restraint following NVCI was used for approximately 30 mins until Calvin was calm and no longer a threat."*

Another example below provides some evidence of aggression "hit and kicked," but there is no further detail to justify the physical intervention. The person's view is reported as N/A. The report describes the type of restraint used and the length of time restrained, but provides little description of the young person's behaviour, attempts by staff to de-escalate the situation or the debriefing process including the young person's perspective. The stock phrasing "*angry and out of control*" gives little clarity about the perception of threat. Did the child hit and kick a staff that was blocking their retreat? Were they hitting and kicking walls? Did the child hit and kick once and stop or did the behaviour continue and escalate? The reader of this next handwritten report is left uncertain if the minimum criteria for use of physical restraint had been met. The child might have been hitting and kicking a person, a wall, once or repeatedly, and perhaps in the context of trying to flee.

> *"Less intrusive measures were being used to deal with Sherice who was angry and out of control, she hit and kicked and it was necessary to hold Sherice in the CPI children's control position for 25 minutes. Afterwards all involved were debriefed."*

As another example, the next situation describes a young person as becoming '*physically aggressive*' with no further descriptive explanation.

One agency, a frequent user of restraint, submitted the same phrase, or with only a few words of variation, in 67% (57/85) of their SORs submitted about restraint.

> *"Became extremely non-compliant and aggressive towards staff and property. After several attempts to re-direct with no success, a restraint was used following NVCI for approximately 20 minutes, at which time was calm and no longer a threat towards self, staff or peers."*

In 194 (9%) of the SORs about restraints, there was no identifiable imminent threat. Here is a case example.

> *"Client re-escalated after returning home from dining hall, which resulted in numerous Safe Management approved containments:*
>
> *60 Minutes, 2 staff, 2 attempted releases*
>
> *20 minutes, 3 staff*
>
> *20 minutes, 3 staff, 2 attempted releases*
>
> *40 minutes, 3 staff, 1 attempted release"*

CLIENT VIEW/ DEBRIEFING PROCESS

Some reports provided a description of the debriefing process, but there was wide variability in terms of how the process was described. The SOR/ESOR form does not have a specific section dedicated to explaining the debriefing of the staff or young person. Some reports mentioned that the "*staff and child were debriefed*" with no further comment.

There is a section on the report that specifically requires a reporting on the person's allegation/ person's view. When this section is completed, it often has wording such as: "*he refuses to take responsibility,*" "*he shows no remorse*" or it is a narrative of the staff's comments to the child, such as "*reminded him that it is not okay to hit staff.*" In the chart on the right, these types of statements are tabulated as "other comments." Occasionally the child is quoted, usually with a reflection of their anger, such as "shut up," swearing or other statement. Sometimes too the child's comments about the restraint are included such as "it hurt," "you held my wrist too hard."

CLIENT VIEW-DEBRIEFING PROCESS

	#	%
Blank	915	41
N/A or non verbal	395	18
Child no longer there	19	<1
Describes child's behaviour	207	9
Other comment	166	7
Quotes child's comment	77	3
Describes child's comment	427	19
No allegation made	24	1

The section for the client viewpoint on the SOR was left blank in 41% of those submitted for *Type #8 Restraint of a Client*. A further 18% indicate that the voice of the child is not applicable (N/A) or described the child as non-verbal. Together, 59% of SORs submitted omit the voice of the child. The child's behaviour was described in 9% of the reports and a further 7% include comments unrelated to the client view. In 23% of the SORs about restraint, the young person's view was captured either by quoting the child or by describing the child's comment. Still sometimes the statement "no debriefing as per ICMP" appears. The ICMP is the Individual Child Management Plan and the statement suggests that a decision was made by staff (including supervisory staff) involved with the care of the child to ignore the legal requirement that a child who has been restrained must be debriefed.[64] They have no legal authority that permits a children's residence, or its staff, to opt out of the legislative requirements under the CFSA.

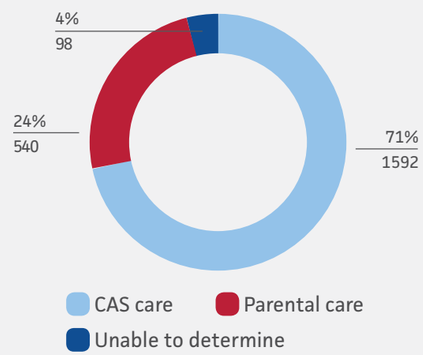
64 R.R.O. 1990, REGULATION 70 s. 109.2.

LEGAL STATUS OF THE CLIENT

It was possible to identify the status of the child by who was notified in the SOR and, in some reports, the legal status of the child was specifically mentioned.

The majority of the children subject to restraint were placed in the children's residence by a children's aid society. Almost a quarter of the SORs about restraint involve children who were placed by their parents. The guardianship status of the child was indeterminable (due to either missing information or redactions) in 4% of SORs under *Type #8 Restraint of a Client*.

STATUS OF CHILD



NOTIFICATION AND ALLEGATIONS OF ABUSE

If there is a serious occurrence, the names of all parties notified are to be recorded on the SOR. Typically it is noted that a parent or guardian was apprised of the restraint.

WHEN INJURIES OCCUR

Occurrences reported as *Type #8 Restraint of Client* contain sub-categories to indicate if there is a) no injury; b) with injury or; c) with allegation. There were 82 SORs that reported subcategory b) indicating an injury resulting from the restraint (or developmental services challenging behaviour and resulted in injury). An additional 62 injuries were discovered by closely reading the narrative of the event for a total of 144 injuries during restraint in this three-month period. In total 6% (144) of the reported SORs about *Type #8 Restraint of a Client* resulted in injury.

The table to the right shows the injuries reported for each type of reported restraint. The Advocate's Office has not specifically named the training programs involved in the incidents because the identified problem of incompleteness in the SOR reports means that we cannot be sure that the numbers are accurate. In 514 SORs (almost 1/4 of the total number received), the type of physical restraint program used is not identified.

The most common type of the injuries were bruising, rug burns and, most frequently, sore or injured arms and wrists. In addition to injuries reported within SORs about *Type #8: Restraint of Client*, there were six *Type #2: Serious Injury* reports of injuries from restraints. One occurrence involved a nose bleed and the other five related to observations made by parents, physicians or other staff members of swelling or bruising on the young person. In four of the 15 allegations of abuse during restraint, there is documentation of injury.

A number of injuries does not necessarily mean that the restraint was unsafe or applied improperly. In fact, a good crisis intervention program positions physical restraint as a last resort, applied only after all other less intrusive measures have been tried and failed. Those that successfully defuse many crisis situations may have higher injury rate, as it is only employed in extreme and rare situations. Nevertheless, tracking the rate of injury does alert oversight bodies to potential risks from a particular restraint method and may identify situations where retraining is needed to ensure fidelity to the method.

NUMBER OF INJURIES REPORTED FOR EACH MINISTRY APPROVED RESTRAINT TRAINING PROGRAM

	Total injuries recorded
Training Program "A"	53
Training Program "D"	28
Training Program "C"	20
Training Program "E"	14
Training Program "B"	8
Training Program "F"	0
Not otherwise specified	21

WHEN ALLEGATIONS ARE MADE

Allegations of abuse during a restraint are to be recorded as a subcategory of *Type #8: Restraint of a Client*. There were six SORs that indicated subcategory c) *with allegation.*

Allegations of abuse during restraint are also captured in *Type # 6: Complaint About Operational, Physical, Safety Standards*; *Type #7 Complaint made by or about a client*, *or other serious occurrence involving a client*; and *Type #3: Alleged, witnessed, or suspected abuse*. The table to the right presents the total number of allegations of abuse in the context of physical restraint.

Twenty-four allegations of abuse during restraint were made during this time period. Of the reports of allegations of abuse during physical restraint, the most were captured under *Type # 3: Alleged, witnessed, or suspected abuse*. Most reported allegations were investigated either internally by the residence or by a local CAS.

ANTECEDENT OF THE RESTRAINT

Each restraint was coded by the research team as to what preceded the restraint situation. The table on the lower right presents antecedents to the restraint.

In this analysis "Required Program" refers to situations when a restraint occurs following a demand to stop an activity (stop watching TV or the requirement to be in their room during meal prep and shift change also known as "quiet time") or to engage in an activity required by the program (join group or attend an outing). Such program demands preceded 24% of the SORs related to *Type #8: Restraint of a Client*. The next largest grouping comprises restraints that follow a conflict with a peer in the residence. Bedtime upset and upset surrounding personal care and toileting precipitate the restraint in 13% of reports of physical restraint. "Transitions" might mean a transition from one activity to the next or in reference to a staff shift change. Difficulties arising from changing activities or going from one activity to the next during a period of transition are implicated in 12% of the reports. The young person is described as not feeling well preceding 12% of the restraints. In 10% (213) of the reports there is no an antecedent mentioned.

ALLEGATIONS OF ABUSE IN THE CONTEXT OF PHYSICAL RESTRAINT

ALLEGATION IN THE CONTEXT OF RESTRAINT	#	%
Type #8 Restraint of client	6	25
Type #6 Complaint about operational, physical, safety standards	3	13
Type #3 Alleged, witnessed, or suspected Abuse	15	62
TOTAL	**24**	**-**

ANTECEDENT OF THE RESTRAINT

ANTECEDENT	#	%
Chores	66	3
Washroom or toileting	109	5
Peer in a restraint	21	<1
Transition	273	12
Required program	536	24
Computer or video game	70	3
Threatened to run away	86	4
Young person's property damaged	12	<1
Bedtime	180	8
Young person not feeling well	26	12
Community outing or appointment	51	2
Peer conflict	293	13
Phone call	45	2
Home or family visit	47	2
After a family visit was cancelled	20	<1
Food or mealtimes	182	8
Not mentioned	213	10

MEDICATION USE IN THE CONTEXT OF RESTRAINT

The use of PRN medication (prescribed "as needed") was noted in many SORs. Each report was coded for reference to "PRN medication administered" or if there was reference to administering medication in the context of a restraint. Typically the medication name was redacted by MCYS. When it was redacted, the report would read "*offered <redacted> and took <redacted>*" and these were coded as such (see table below). Sometimes more than one PRN was recorded as having been administered in the context of an occurrence.

However, there was a number of SORs where this information was not redacted. Medications such as Seroquel (anti-psychotic), Olanzapine (anti-psychotic) and Lorazepam (benzodiazepine) were listed in the narrative. All of the above medications list respiratory depression as a potential side effect. Benzodiazepines are controlled substances in Ontario.

The use of PRN medication in and of itself is not a concern presuming that the medication is properly prescribed; however, when this is considered in the context of the findings of this review regarding medication and the risks associated with use proximal to physical restraint, the need for oversight and safeguards becomes apparent.

A total of 215 SORs indicated that a PRN was administered in the context of restraint and in an additional two SORs, administration of a PRN was implied by phrases partially redacted such as "*was offered <redacted> and took <redacted> at 3pm.*" An additional two are reported as 'chemical restraint' administered in a hospital setting (with three more reported with type *Type #7: Complaint by or about a Client or Other Serious Occurrence*). Taken together this indicates that psychotropic medication is used in the context of a restraint in 10% of reports of physical restraint.

USE OF PSYCHOTROPIC MEDICATION IN THE CONTEXT OF RESTRAINT

	#	%
PRN administered	215	
Offered and took <blank>	2	
Chemical restraint (hospital)	2	
Total % of PRNs in context of restraint	219	10

SELF-HARMING BEHAVIOUR IN THE CONTEXT OF RESTRAINT

As mentioned earlier, self-harming behaviour features frequently in the SORs submitted. This next chart shows the number of these SORs under *Type #8: Restraint of a Client.*

Self-harming behaviours feature in 21% of the SORs in the category of *Type #8: Restraint of a Client.*

RESTRAINT AND SELF-HARMING BEHAVIOUR

	#
Self-harm and restraint	455

POLICE CONTACT IN THE CONTEXT OF RESTRAINT

The police attended the residence in the context of a physical restraint in 6% of the SORs about *Type #8: Restraint of a Client.*

POLICE CALLS IN THE CONTEXT OF #8 RESTRAINT OF A CLIENT

	#	%
Police and restraint	139	6

RESTRAINT TO YOUNG PEOPLE WITH DISABILITIES

Young people with disabilities are uniquely vulnerable as their disability may inhibit their ability to raise concerns and as such intrusive measures with this population requires enhanced vigilance. There were 829 (37%) SORs about physical restraints of young people known to or believed to have a developmental disability or have a disability identified. Of these, 213 report more than one restraint for a total of 1,184 (39%) restraints. This is a rate of 13 restraints each day of young people with a known or suspected disability during the 90-day period of this review.

The antecedent was unclear or not mentioned in 14% of the occurrences. Transition periods and demands made of the young person by the program comprise 31% of the precipitants to the restraint. A physical restraint occurring in the context of personal hygiene care or toileting of the young person is the precipitant in 8% of the SORs about restraint of a young person with a known disability. Upset around bedtime accounts for another 7% and peer conflict precipitated the restraint in 12%.

SAFETY DURING PHYSICAL RESTRAINT AND DISABILITY

In 38/829 (6%) SORs, the restraint was aborted because it was unsafe or too difficult to maintain. The use of helmets or protective mechanisms were very rarely described in the SORs and it may be that they are used and simply not recorded on the report form, perhaps not viewing the information as important.

PHYSICAL RESTRAINT, PRN AND DISABILITY

A PRN was described as being administered in the context of restraint in 134 of the SORs related to young people with disabilities. This indicates that young people with or suspected to have a developmental disability account for 62% of the use of PRN medication in the context of restraint.

The description in one SOR, as noted below, relates to an occurrence that began as the young person returned to the residence after a visit with his parents.

> *"Paul had returned from a late dinner outing with his parents. Paul was pushing against staff and grabbing hair. Staff called for help as Paul was still grabbing staff, knocking off staff's glasses, hitting staff. Police were called (but did not arrive until 1 hour later when Paul was calm). At this time a prn was administered to Paul and a call to the Supervisor. Supervisor talked with the staff, advising how to calm Paul, offering suggestions and verbal support. Staff used some of the ideas that the supervisor offered and Paul began to calm. Staff ended the call with the Supervisor as the overnight staff came in and Paul showing signs of calm. As Paul began to escalate again so staff decided to administer the second prn as directed on his prescription. Paul calmed with staff support by showering and changing him. Paul slept from 1am until 7:30 am."*

Two PRN were administered. The police were called for support, but they did not arrive until after the young person had begun to settle.

ANTECEDENT TO PHYSICAL RESTRAINT OF YOUNG PERSON WITH A DISABILITY

ANTECEDENT	#	%
Chores	22	2
Washroom or toileting	63	8
Peer in a restraint	3	<1
Transition	118	14
Required program	142	17
Computer or video game	15	2
Threatened to run away	25	3
Young person's property damaged	3	<1
Bedtime	62	7
Young person not feeling well	17	2
Community outing or appointment	23	3
Peer Conflict	100	12
Phone call	17	2
Home or family visit	14	2
After a family visit was cancelled	4	<1
Food	84	10
Sudden and unexpected or not mentioned	117	14

OTHER RESTRAINT FINDINGS:

SAFETY

There were numerous examples of situations where young people and staff appeared to be concerned for or unable to maintain their safety. This included situations where young people were in a behavioural crisis in a vehicle. There were 64 applications of restraints used while the young person and staff were in or near a vehicle.

Sixteen reports of restraint resulted from actions occurring while the vehicle was in motion. Sometimes this action was an attempt by a young person to exit a moving vehicle, while other times this precipitant was self-harming behaviour or aggression towards others. Just under half of the restraints associated with a vehicle occur near a vehicle. In some cases, these are situations where the staff were in a vehicle following a young person who had left without permission. Other times, these incidents occurred arriving or departing from appointments and visits. In 18 of the restraints, the incident began while the vehicle was parked.

RESTRAINTS ASSOCIATED WITH A VEHICLE

	#
Vehicle in Motion	16
Near Vehicle	30
Parked	18

There were also situations in which a restraint was initiated and had to be aborted for reasons of safety. This might have occurred because the staff did not have the physical strength to restrain the individual or due to positional concerns that emerged while implementing the restraint.

There were 73 restraints that were aborted, representing 3% of the physical restraints.

RESTRAINT ABORTED

	#	%
Restraint aborted	73	3

"I CAN'T BREATHE"

The *Type #8: Restraint of client* SORs had 66 references to young people complaining of being unable to breathe.

> *"He insisted that he couldn't breathe throughout the containment."*
>
> *"X expressed that he was unable to breathe throughout the containment."*

Regulation 70, 109.1 (1) 8 states that "[d]uring physical restraint of a resident, the resident's condition must be continually monitored and assessed." In SORs that contained a reference to a young person being "unable to breathe," there were statements indicating a staff member's perception that because a young person was still talking or yelling that their breathing was not impaired.

The following are examples of written responses to young people's claims that they were having trouble breathing during the restraint.

> *"was communicating with staff throughout the restraint indicating a clear and open airway."*
>
> *"X was yelling at staff during the Escort demonstrating a clear and open airway."*
>
> [PMAB] *"He was continuously yelling at staff while going into the blue room, this was showing open airways." >*
>
> [PMAB] *< He was communicating with staff throughout the restraint indicating a clear and open airway."*

While there were indications of some situations when staff readjusted their positioning, sought an additional staff to monitor the child's face and status or the child was released, there were SORs where the reporting suggested that there was no response to the child's expressed distress. Insufficient research has been conducted on the various methods of restraint to fully understand the risks of positional asphyxia.[65] Evidence from adult populations suggests that this is a potential risk worth monitoring.[66] The risk of paediatric asphyxia appears to be misperceived and there is an immediate need for corrective direction to the field.[67]

WITNESSING A PEER IN RESTRAINT

During the review it became evident to the researcher that there were times when the restraint was precipitated by a peer who was also being restrained. These situations were specifically examined to determine the frequency in which witnessing a peer being restrained triggers an emotional response in another child that leads to restraint of that child.

NUMBER OF TIMES THE ANTECEDENT IS A PEER IN RESTRAINT

	#
Peer in restraint	21

In 21 reports about the physical restraint of a child, witnessing the restraint of another child was identified as the precipitator to the serious occurrence.

CONFUSION

CONFUSION OVER WHEN SOR REPORTING IS REQUIRED

There is clearly confusion about the required detail needed to meet the *SOR Guidelines* and there is evidence of confusion even about when an SOR should be written. This next SOR is about at least two restraints ("maintenance position hold" and later "straight arm on shoulder") that were both aborted because it was unsafe and the staff were unsure if aborted restraints required a report.

> *"Due to the number of attempts, a decision was made to file an SOR as even though X was not actually held in PMAB hold, there was hands on contact between staff and X during the attempts."*

There seems to be a lack of clarity for some practitioners when developmentally appropriate hand holding or gentle guiding crosses the line into restraint. It quickly became a challenge for the researcher and coders in this review to differentiate between gentle guiding and hand holding and "*physically prompted*" or "*physically guided*" and "*physically escorted*." As a reminder, the *SOR Guidelines* contains the following exclusion:

> *"Does not include the restriction of movement, physical redirection or physical prompting if the restriction of movement is brief, gentle and a part of a behaviour teaching program, or the use of helmets, protective mitts or other equipment to prevent a resident from physically injuring or further physically injuring himself or herself."*

The researcher noted once again that there were very few instances of the use of protective equipment and no mentions of helmets or protective mitts, despite considerable mention of SIB-like behaviours. The Self-Injurious Behaviour known to occur with individuals with developmental disabilities was discussed earlier in this report.

65 Ball, H.N. (2005). Death in restraint: lesson. *Psychiatric Bulletin*, 29, 321-323.; Michaud, A. (2016). Restraint related deaths and excited delirium syndrome in Ontario (2004-2011). *Journal of Forensic and Legal Medicine*, 41, 30-35.
66 Berzlanovich, A.M., Schopfer, J. and W. Keil (2012). Deaths due to physical restraint. Dtsch Arztebi Int, 109(3), 27-32. DIU: 10.3238/arztebi.2012.0027.; Tolson, D. & Morley, J.E. (2012). Editorial: Physical restraints: Abusive and harmful. JAMDA, 13, 311-313; Gill, J.R. (2014). The syndrome of excited delirium. *Forensic Science Medical Pathology*, 10: 223-228.; Hollins, L.P. & Stubbs, B. (2011). The shoulder: taking the strain during restraint. *Journal of Psychiatric and Mental Health Nursing*, 18, 177-184.; Karch, S.B. (2016).The problem of police-related cardiac arrest. *Journal of Forensic and Legal Medicine,* 41, 36-41.
67 Mohr, W.K., Petti, T.A. and Mohr, B. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry* 48,(5), 330-337.; Nunno, M.A., Holden, M.J. and A. Tollar. (2006) Learning from tragedy: a survey of child and adolescent restraint fatalities. *Child Abuse and Neglect*, 30, 1333-1342.

CONFUSION OVER HOW TO CLASSIFY RESTRAINTS

Many restraints are coded as *Type #7: Complaint by or about a Client or Other Serious Occurrence Involving a Client*. It is within these reports that instances where young people are charged with assault or property damage are most likely to appear. Additionally, restraints are reported as *Type #2: Serious Injury*. This variability in recording obscures the true rate of physical restraint, injury by physical restraint and charges as a result of crisis situations.

UNUSUAL DESCRIPTIONS OF RESTRAINTS

There were a number of examples of restraints that seemed to have unusual descriptions and did not appear to be consistent with any approved training technique.

> *"staff moved in with a ½ moon containment."*
>
> *"Bear hugged."*
>
> *"Wrapped his arms around him and sat him on his lap to soothe him."*

We can conclude that the SORs about restraint do not contain sufficient information to justify use of force in 44% of the total submissions. Few reports met the *SOR Guidelines*, particularly in those situations where the child is known to have, or believed to have, an intellectual disability. In these cases, MCYS was provided insufficient information to ensure that this intrusive intervention was applied according to the legal authority.

DISCUSSION ON PHYSICAL RESTRAINT

Physical restraint is an intrusive intervention that has risks associated with its use. As noted in a Canadian Journal of Psychiatry (CJP) review paper:

> *"Use of physical restraint cuts across all ages and types of health and human service settings. Reports of lethal consequences proximal to their use raise the issue to a life-and-death matter that demands attention from professionals."*[68]

In the Ontario context, two separate inquests into the deaths of young people in children's residences (both of whom were 13 years of age) each identified concerns with the safety of physical restraint, and made recommendations to further safeguard young people when restraint is used. In one case, the jury verdict lists the cause of death as "Hypoxic-ischemic encephalopathy secondary to cardiopulmonary arrest associated with restraint in the prone position for psychiatric agitation"[69] (emphasis added) and in the second, the cause of death is listed as "Hypoxic Encephalopathy and Bronchopneumonia due to asphyxia while being restrained"[70] (emphasis added). It is worth noting that the jury at the inquest into the death of one of the young people returned a verdict of homicide.

Internationally, the use of physical restraint with children and youth has also received a fair bit of concern. In 1997, the *Hartford Courant* published an investigative report revealing deaths related to intrusive measures in institutional care.[71] Michael Nunno of Cornell University, a leading expert on physical restraint, and his colleagues examined 45 child and adolescent fatalities related to restraint in US residential placements over a 10-year period. Their review found inadequate documentation about the interventions used and the rationale for use. Few of the cases reviewed in their examination of child deaths met the criteria for imminent threat. They note that "signs of breathing restrictions or distress were present in 13 fatalities in which the child is reported to have said "I can't breathe" prior to unconsciousness or death."[72] As mentioned, this review found that 66 of the SORs about restraint document that young people had expressed concern about their ability to breathe or that they were experiencing pain from the restraint.

68 Mohr, W.K., Petti, T.A., and B.D. Mohr (2003). *Canadian Journal of Psychiatry*, 48(5):330-337.
69 (2002) Verdict of Coroner's Jury on the Inquest into the death of SJ
70 (2001) Verdict of the Coroner's Jury on the Inquest into the death of WE
71 Weiss, E.M., Altimair, D., Blint, D.Fand K. Megan (1998, October) "Deadly restraint: A Hartford Courant investigative report." *Hartford Courant*.
72 Nunno, M.A., Holden, M.J. and A. Tollar (2006). "Learning from tragedy: A survey of child and adolescent restraint fatalities." *Child Abuse and Neglect*, 30: 1333-1342.

The CJP review paper referenced earlier examined the research surrounding asphyxia proximal to restraint, noting that, while prone restraint [face down] "*may predispose them to suffocation, restraining patients in a supine position* [lying on the back] *may predispose them to aspiration.*" The authors concluded that "*no data are available to speak to the relative safety of one position over the other.*" In addition to asphyxia, a number of other factors were identified that have been implicated in deaths following restraint such as blunt trauma to the chest, catecholamine rush (massive release from the adrenal gland), adverse impacts of psychotropic medications, Rhabdomyolsosis (associated with benzodiazepines and substance abuse) and Thrombosis and Pulmonary Embolism.

At the same time, the healthy development of a child requires physical contact with others.[73] In a way that is similar to parenting, residential care providers engage physically in the young person's environment. They put young people to bed, assist with personal care and engage with them in their day-to-day routines. As seen in the SORs, when young people are struggling to control their impulses and cope with their own emotions, front line staff are called upon to assist the young person in de-escalating and supporting them in learning to self-regulate their emotions. Sometimes these young people put themselves and others at high risk of harm and the care provider should be well prepared to safely physically contain the young person.

Because of the risks involved, it is imperative that every use of restraint is documented in a transparent manner and examined with the goal of seeking to understand ways to prevent re-occurrence. This review found insufficient information to justify the use of a physical restraint in almost 45% of the SORs about physical restraint. Furthermore, the perspective of the young person - which is required - was omitted in 59% of SORs. This is not acceptable. The Advocate's Office takes the position that the standard that must be imposed is clear and descriptive reporting that presents an unambiguous and distinct picture of the course of events, from both the perspective of the people applying the restraint and that of the young person. Furthermore, a requirement by oversight bodies that a service provider explicitly identify the imminent threat that led to the use of a physical restraint would demonstrate that a child in care's Charter right to security of the person is taken seriously by the Ontario government, children's aid societies and other placing agencies who are responsible for that young person.

73 Steckley, L. (2012). "Touch, physical restraint and therapeutic containment in residential child care." *British Journal of Social Work*. 42:537-555.

THE STATE OF THE KNOWLEDGE ABOUT RESTRAINT

There has been a steady evolution of research over the past decades exploring the use and risks of physical restraint, primarily relating to adults, but some research has also explored its use with children. The consistent conclusion arrived at in research on the physical restraint of children is that it is a highly intrusive intervention that requires ongoing monitoring, training and vigilant oversight. There is very little research that explores the physiological safety of restraint methods. Some studies examine the perception of the staff or young people about the safety of the restraint.

Martha Holden at Cornell University[74] identified a general consensus in the research literature that an individual should be pre-screened for medical clearance to determine what, if any physical restraint, is safe to use. Reviews of fatalities have implicated positional asphyxia and thoracic and neck compressions as being associated with the deaths of adults.[75] It is quite probable that children are at least as likely to be subjected to these risks and possibly are at increased risk due to their physiological immaturity.[76]

There is significant concern, confirmed in the literature, that positional asphyxia occurs in some situations involving the use of physical restraint.[77] There is debate about the degree to which positional asphyxia is implicated in the deaths of adults and children that occur proximal to physical restraint, particularly those applied in the prone position. Studies of seniors have found that positional asphyxia is implicated in some deaths associated with falls and mechanical restraint. Studies of individuals with physical disabilities have made similar findings associated with the use of mechanical restraint.

74 Holden, M.J., Izzo, C., Nunno, M., Smith, E., Endres, T., Holden, J.C., & Kuhn, F. (2010). "Children and residential experiences: A comprehensive strategy for implementing a researched-informed program model for residential care." *Child Welfare*, 89(2), 131-149

75 Nunno, M.A., Holden, M.J. and A. Tollar (2006). "Learning from tragedy: A survey of child and adolescent restraint fatalities." *Child Abuse and Neglect*, 30: 1333-1342.

76 Knowles, M.M. (2013). "What have we learnt so far about child and adolescent restraint in our health and social care services?" *Journal of Psychiatric and Mental Health Nursing*, 20(9), 851-852.

77 Hayashi, T., Buschmann, C., Correns, A., Herre, S. and M. Tsokos (2012). Fatal positional asphyxia. *Forensic Science Medical Pathology*, DOI 10.1007/s12024-012-9345-y.; Michaud, A. (2016). Restraint related deaths and excited delirium syndrome in Ontario. *Journal of Forensic and Legal Medicine*, 41, 30-35.

It is noted that there is a line of research inquiry which suggests that the use of prone restraint and/ or the use of force required to place aggressive individuals in a prone position does not adversely impact cardiovascular functioning and does not place individuals at risk for positional asphyxia. For example, Savaser et al. studied 25 male volunteers recruited from a university campus. The volunteers were put in five different body positions (supine, prone, prone maximal restraint without weight, prone maximal restraint with 50 lbs on the centre of the back, prone maximal restraint with 100 lbs on the centre of the back). The researchers concluded that their findings "did not support the contention that [prone maximal restraint] with or without weight force up to 100 pounds results in a decrement of CO sufficient to cause cardiovascular collapse."[78] Other researchers have also raised questions about conclusions based on experimental conditions "removed from what occurs in real life."[79]

Despite the controversies in the academic literature, this report documents the clear fact that during the period of June 10-December 31, 2016, the Advocate's Office received 131 reports of injury proximal the use of a restraint (such as soft tissue damage, bruising, swelling, and complaints of pain), three incidents of fractures to a bone, and two cases in which a young person fell unconscious during the use of a physical restraint.

Wanda Mohr and Michael Nunno,[80] both respected experts in the use of physical restraint on children, argue for the need for fully informed consent and assent for the use of restraint. They point out that while it has not been the norm to seek assent and consent in children's residences, there is an ethical imperative to provide full disclosure of the risks and benefits of physical restraint. They summarize the current state of knowledge about restraint by noting that:

> *"no studies substantiate that they are clinically efficacious in anything but containment of violent behaviour. What few evaluations of restraints exist conclude that they are ineffectual, and sometimes counterproductive (Garrison et al. 1990; Natta et al. 1990; Singh et al. 1999). The "therapeutic" use of restraints has been touted (Bath, 1994), but does not go beyond the theoretical and offers no evidence for their therapeutic benefits. There is a growing body of literature discussing the dangers and unintended consequences associated with use (Mohr et al. 2003; Nunno et al. 2006). Research literature also suggests that despite training protocols, staff members' actions are often antecedent to violent episodes requiring the use of restraints (Garrison et al. 1990; Goren et al. 1993; Natta et al. 1990)."*

BEHAVIOURS BASED ON EMOTIONAL PAIN

Many young people in residential care have experienced trauma, loss and instability. Most young people in this review were involved with a children's aid society and this suggests a potential history of maltreatment that may have placed their healthy development at risk. In Ontario, there is a preference for family-based care and as a result, residential care has come to be viewed as a last resort. By the time many of these young people were admitted to children's residences, they would likely have already experienced at least one foster care setting. In addition, the loss associated with separation from parental care is compounded by further losses due to placement changes and disruption to social, school and other routines. Most of the young people referred to in these SORs have likely experienced repeated loss and trauma.

Laura Steckley, of both the University of Glasgow and Strathclyde, discusses the complexity of the context in which these young people find themselves living, in pain, in residential care. Commenting on the Scottish policy context that sees residential care as a last resort, she makes the following observation.

78 Savaser et al. (2013). The effect of prone maximal restraint position with and without weight force on cardiac output and other hemodynamic measures. *Journal of Forensic and Legal Medicine* (20) 991-995. p.994.

79 Tamsen, F and Ingemar Thiblin (2014). Deaths during apprehensions of agitated persons. A review of proposed pathophysiological theories. *Scandinavian Journal of Forensic Science* (20), 3-8 p.7.

80 Mohr, W.K., & Nunno, M.A. (2010). Black boxing restraints: The need for full disclosure and consent. *Journal of Child and Family Studies*, (20), 38-47.

> *"Such ambivalence contribute to the above-mentioned poor levels of qualification, as well as the degree of aggression and violence encountered in some establishments. It is only those children and young people with the most serious difficulties who are placed in care (Forrester, 2008), and by the time they enter residential child care, they have experienced significant abuse or neglect and / or multiple placement breakdowns (sometimes as a result of all-cost efforts to avoid residential placement). Resultant interruptions to their healthy development and damage to their ability to make and sustain attachments can be profound. This often manifests in challenging and sometimes disturbing behaviour, and the less equipped staff and organisations are in terms of knowledge, skills and use of self, the greater the chances physical restraint will be misused."*[81]

Young people are evolving developmentally and their cognitive immaturity limits their ability to process trauma and loss. Many function at a state of hypervigilance readying themselves to face the next threat.[82] Some are reactive and functioning in the state of fight or flight, constantly flooded by emotions and overwhelmed by the cascade of neurochemicals and hormones that are released by trauma and fear.[83] Within this review, there is a catalogue of emotional pain-based behaviours.[84] These SORs detail young people lashing out emotionally, before bedtime, following visits and phone calls with family and while navigating interpersonal relationships. As discussed earlier, the prevalent self-harming behaviours and aggressive acting out towards people and property may be manifestations of an immature mind overwhelmed by the impacts of trauma and loss.

THE LANGUAGE OF RESTRAINT

Situations of crisis are by their very nature high stress, involving individuals in a state of fight or flight, a heightened state of arousal which diminishes their cognitive ability to process language. The language used during a physical restraint needs to be purposeful, calming, and in a tone that soothes rather than escalates the situation. Moreover, the language staff use to frame their intervention helps to determine their own sense of security. When the worker uses phrases like "take him down," as found in some SORs, they are linguistically prompting themselves to be in a heightened state of anticipation and sense of threat.

WALK BY TAKE DOWN
had to go hands on
RESTRAINED USING THE ENVIRONMENT
HOLD **BEAR HOLD** *aggressed towards the*
CONTAINED *environment*

DE-ESCALATION NOT ESCALATION

The regulations require that restraint be used only after attempts at de-escalation have been tried and failed or are not practical.[85] Attempting to deflect aggression rather than react is the preferred intervention when a young person begins to lose self-control. All of the approved restraint techniques place de-escalation of the incident as a first-line response. By attempting to soothe, and calm the young person, a front-line staff member can assist the young person in regaining control. The actions of the staff member are key in a crisis situation as we know that individuals in crisis have a reduced ability to process language and will likely react to physical intrusion as if it were a threat. According to the approved restraint techniques, actions such as backing away, trying to distract or allowing controlled verbal venting and controlled physical release all help to reduce the intensity of the emotion and allow the individual time to defuse.

81 Steckley, L. (2010). Containment and holding environments: Understanding and reducing physical restraint in residential child care. *Children and Youth Services Review*, (32), 120-128, p.120.
82 Maté, G. (2003). *When the body says no: Understanding the stress-disease connection*. New Jersey: Wiley & Sons.
83 Terr, L. (1990). *Too afraid to cry: Psychic trauma in childhood*. New York: Basic Books.
84 Anglin, J. (2002). *Pain, Normality and the Struggle for Congruence: Reinterpreting residential care for children and youth*. New York: Haworth Press.
85 RRO 1990, Reg 70, s.102.

The reports submitted by service providers analyzed for this review suggest that the physical restraint techniques used were safely applied in the majority of cases; however, more research is needed to fully understand the rate of injury for each of the different approved restraint techniques. This review found a report of an injury, typically reported as minor, in 6% of the reports about restraints. Once restraint is used, a plan should be developed to clearly outline the techniques that are effective at de-escalating the situation and should include defined prompts, known both by the young person and the staff that would trigger more intrusive interventions. This review found very few examples of SORs where the attempts to de-escalate were clearly described. Rigorous review of these events, in a manner that allows for learning and skills development, presents an important opportunity to enhance practice and safeguard young people and staff. Repeated use of restraint suggests the need for broader training, clinical enhancements and ongoing monitoring.

TRAINING MODEL FIDELITY

There is little understanding about the degree to which staff in the field operationalize what they learned in the training program. More research is needed to understand how these restraints are applied in real-life situations.[86] The training uses a train-the-trainer model and it is of concern that there is no published research on the systematic review of compliance with the program methods. Viewing the use of repeated restraint as an indicator of greater clinical need presents an opportunity for research and enhanced service delivery.

86 Nunno, M. A., Holden, M. J., & Leidy, B. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility, *Children and Youth Services Review*, 25(4). 295-315.

9. USING DATA TO IDENTIFY PATTERNS

Even though the data is difficult to compare, it was possible to use a sorting method that filtered down the results such that it consistently identified 13 agencies that could be distinguished from the rest. The data presented here gives an example of how SORs can be used to identify trends and patterns in residential programs. It is important to understand that identification on any one of the lists below does not necessarily mean there is a problem at the particular residence. It simply provides a data point that might provide an early warning of potential problems. At the very least, this data suggests that further examination is warranted.

The first level of analysis identified the 15 agencies with the most SORs submitted. It is important to remember that the largest number of SORs does not necessarily indicate a problematic agency. In fact, the review team was generally more concerned about the 315 agencies that the Ministry of Children and Youth Services reported as having not submitted any SORs during this time period. Nevertheless, it is important to know which agencies are reporting the most frequent number of these events.

The agencies reporting the highest numbers of total restraints generated an additional list. A third list was compiled by listing the agencies that had the highest numbers of agency calls for police assistance.

When these lists were combined, 13 agencies had a high number of serious occurrences, high number of physical restraints, high number of calls to police, and a high number of red flags such as multiple restraints, injuries or no imminent threat apparent. As discussed earlier, the names of the agencies are not being published in this report for reasons of fairness; however, the types of residences in this list include group homes and children mental health centres. This chart documents the data that can be extracted from close review of the reports about physical restraint from these agencies.

Agency "H" particularly stands out due to the 81% of the reports in which the "imminent risk" was not apparent. Agency "L" reported an injury in 50% of reports about the use of physical restraints.

13 FREQUENT USERS OF RESTRAINT, MULTIPLE REPORTS AND CALL TO POLICE

AGENCY	INJURY RATE	MULTIPLE RESTRAINTS	HURT/OR CAN'T BREATHE	NO THREAT IDENTIFIED	% THREAT NO/ UNSURE
A	4%	36	0	17	38
B	7%	76	12	13	30
C	16%	72	1	4	61
D	<1%	29	0	7	11
E	14%	27	1	16	32
F	16%	15	19	4	29
G	8%	41	0	6	34
H	<1%	1	0	4	81
I	10%	21	13	22	48
J	8%	1	1	14	36
K	9%	18	0	3	28
L	50%	2	0	0	30
M	0	0	0	1	57

There are numerous possible reasons that some reports do not, on face value meet the legal justification for use of force. The reports are poorly written and this might contribute to the high number of reports where it is difficult to determine the imminent threat. Nonetheless, as the previous table demonstrates, rigorous and timely analysis does point to agencies that require attention to ensure that they are operating within the parameters of the standards.

Two agencies had the most number of restraints and they tied for the fourth highest number of calls to police. These two agencies were examined more closely to understand the nature of these calls and the findings are discussed in this next section.

Agency A reported a total of 218 restraints while Agency B reported a total number of 135 restraints.

Each report was analyzed to determine if a clear imminent threat was described in the SOR to justify the use of force. Where multiple restraints are reported the first restraint was examined to make this determination.

In 42% of the reports, Agency A does not provide sufficient detail to justify use of force while Agency B had 33% of reports providing insufficient information to that end. The reports by Agency A clearly identify an imminent threat in 58% of reports about restraint and Agency B provides details about an imminent threat in 67% of the SORs about restraint.

The third table on this page examines the documentation of the young person's perspective on the restraint which is to be provided in a section on the SOR form.

None of the reports submitted by Agency A about restraint include the viewpoint of the young person. In 71% of the SORs about restraint for Agency B, the young person's views were either quoted or described.

Each report was examined to determine the completeness of the form for demographic information needed to understand the report, such as the name and position of reporter, and the date and time of the incident. A complete report would allow someone receiving the report to be able to contact the person submitting the report for follow-up.

Most reports by Agency A include complete demographic information necessary such as date and time and name and position of reporter. For Agency B, there is insufficient information in 9% of the SORs about restraint to be able to identify the reporter.

RESTRAINTS

	Agency A	Agency B
Total reports	170	94
Total with more than one restraint	34	41
Total actual restraints	218	135

USE OF FORCE JUSTIFIED

	Agency A	Agency B
No	18	6
Unsure	53	25
Yes	99	63

YOUNG PERSON'S VIEW

	Agency A	Agency B
Blank	167	0
YP discharged	3	0
Describes YP comment	0	54
Describes YP's behaviour	0	19
Quotes young person	0	12
Other comment	0	7

REPORT COMPLETE

	Agency A	Agency B
Complete	167	84
Missing key information	3	8

DISCUSSION ON TRENDS AND PATTERNS

As demonstrated in these findings, a rigorous review of serious occurrence reports yields valuable information that can be used to inform practice and safeguard young people in care. A comprehensive analysis of these documents has the potential to reveal crucial information about the care of a particular child, deviations from policy, trends at individual residences, patterns across facilities, and systemic issues that would not otherwise have been brought to light. The findings point to the need for a centralized database that captures serious occurrences at children's residences, which includes the tracking of instances of emergency personnel involvement.

10. SILENCE, EMOTIONAL PAIN, AND THE LANGUAGE OF CARE

YOUNG PEOPLE'S VIEW OF EVENT

A section on the SOR has space for filling in the young person's viewpoint or any allegation made by the young person about the event. In the case of physical restraint, the *SOR Guidelines* require it. Nonetheless, the young person's view of the event is included only rarely and, when it is, it often emphasizes statements made by the young person that support the characterizations included by staff. As noted in an earlier section, the portion of the SOR where the young person's view could be recorded by staff was left blank in 41% of those submitted for *Type #8 Restraint of a Client*. A further 18% indicate that the voice of the child is not applicable (N/A) or described the child as non-verbal. Together, 59% of SORs submitted omit the voice of the child.

In 95 SORs, the words "non-verbal" is all that is listed in this section. This implies that a non-verbal young person has no possible way of expressing their views. This approach is inconsistent with current best practices in assisted communication. For example, a simple PEC (Picture Exchange Communication) system could be used to debrief the young person.[87]

WHEN YOUNG PEOPLE NEED HELP

The majority of the young people referred to in these reports are associated with a children's aid society. Arguably they are some of the most at-risk young people in the province. Placement in residential care can isolate young people from their kinship network and from natural advocates. In this review, it was determined that a small number of young people called out to the police and to the Provincial Advocate when they felt that they needed help.

YOUNG PERSON CALLED THE ADVOCATE OR POLICE

CALL TO POLICE	#
Young person called 911 or asked to call police	15
Young person called Advocate	14

The young people themselves called 911 on 15 occasions. Sometimes the young people were calling about themselves and sometimes they were calling about concern for a peer. There were 14 mentions of calls to the Advocate's Office. In eight of these reports, it would appear that the serious occurrence noted is the fact that the young person has made a call to the Advocate.

> *"A client was in a containment with 2 staff. Kim became upset hearing Diana yelling and crying and ran into the hallway and began hitting the relief staff who was holding that client. Relief staff A and relief staff B, come in between Diana and the staff and were able to talk [take] her into the other room. Staff reminded Kim about the importance of everyone's safety and that they were not hurting the other client but keeping her and everyone else safe. After a few minutes, Kim ran and grabbed a phone saying she was calling the police on staff for hurting the client. Kim quickly dialled 911 and told the dispatcher that staff were hurting a girl. Staff took the phone from Kim and let the dispatcher know that the police were not needed. An officer arrived a few minutes later as a result of the 911 call. The officer first spoke with the client being contained then with Kim. Officer S spoke with Aisha about the use of 911 and when to call. He let her know that the staff had the situation under control and they could make the call if it was needed. Staff again spoke with Kim about safety and let her know we were not here to hurt anyone, but help them and to keep them safe. Kim was able to accept this and move on with her routines."*

It is possible that the young person was distressed by what she witnessed and sought the help of 911.

87 Lerna, A., Esposito, D., Conson, M. and A. Massagli (2014). Long –term effects of PECS on social-communicative skills of children with autism spectrum disorders. *International Journal of Language and Communication Disorders*, 49(4), 478-485.

LOSS AND UPSET

The SORs detail young people facing considerable loss and expressing enormous upset. By definition, the SORs are all about upsetting incidents in the lives of children. Below is an SOR that details the struggle of one young person as they adjust to their new living environment.

Over several days, the young person, a Crown Ward at some distance from their home community, struggled to adjust to a new residence. She tried to run several times, jump out of a window and there are repeated reports of restraint. The final report in the series outlines:

> *"Crown Ward struggled with being told she is moving to a new residence in Scarborough today. She began to bite, punch, kick and push staff. Staff members A, B, C, and D place her into a prone restraint in the den at 8:15 a.m. Case Manager E witnessed the restraint. She struggled and bit staff many times. She yelled that she couldn't breathe, that staff were hurting her, and that they were "perverts." Staff readjusted to ensure proper positioning throughout the restraint. Staff members switched to supine restraint due to her struggling after 30 minutes. Staff attempted to loosen their hold on her but she was still unsafe; staff C decided that all staff should remove their hands because she was not calming down effectively. This calmed her down enough to finish packing and get ready to leave. She cried and hugged staff for a while."*

She then proceeded to lock herself in the bathroom, cause damage to the property and throw objects at staff and was again restrained. In the section for the young person's view, it states:

> *"She did not identify any issues after the restraint except for saying that she did not want to leave <the program>. She was able to call her grandma and inform her she's moving today. She seemed to understand she was restrained because she was assaulting staff."*

This next incident begins when a young person wants to bring home art work she had done in school and she was not allowed to do so. No mention is made of how important her work must have been to her and there is no evidence in the narrative of attempts to de-escalate the situation.

> *"Young person had asked to take her unfinished art project home with her and this was denied. She became upset and 'said that wasn't fair and became vocal, yelling at staff and refusing to clean up her area'. She refuses the instruction to go to the hallway. The report continues that "Staff labelled with her that she needed to be in the hallway, and if she was not able to get there on her own she would need to be moved as she was making the classroom unsafe. She stated that if staff touched her she would report them to her CAS. She then began kicking at staff." She was given two warnings and then escorted to the hallway and then restrained for 20 minutes."*

This next report details the upset by a young person over a missing cherished possession.

> *"After dinner a non-verbal young person became upset as he had lost his Piglet stuffed animal. It seems apparent that the staff were aware of the significance of this object to the young person as the report states that staff A 'asked staff B to call the On-call Manager C to get authorization for a PRN as it didn't look like they were going to be able to find Piglet.' The On Call Manager reminded the staff that the young person had the toy during dinner and wondered if it had fallen in the garbage when the young person was scraping off their plate to be washed. The staff retrieved the Piglet from the trash and washed off the toy and returned it to the young person. "Then for no apparent reason Jeffrey went over to staff member D and head butt her in the face. Staff A the blocked Jeffrey from being able to continue towards staff D, but he then grabbed her by the shirt and pulled her to the floor."*

YOUNG PEOPLE ASKING FOR MORE SUPPORT AND HELP

Many SORs describe young people asking for more support and assistance. This next restraint incident describes the young person's pleas for more support. After repeated attempts to leave the residence and three restraints, during a debriefing with staff it is reported that:

> *"while in the containment, X kept saying 'I need more therapy.' <Agency name> isn't helping me at all."*

This next restraint report also discusses a young person requesting hospitalization. After attempting to run out onto the fire escape and while in a physical escort, staff report that:

> *"She pleaded for PRN but she had been given her entire daily maximum for today. She was very loud and disruptive to younger peers trying to sleep. She was demanding staff to phone police so she could go to the hospital to be sedated."*

A child from out of the province complained of not wanting to be in the program. He was restrained to prevent harm from banging his head against a wall while yelling:

> *"I want to live with my sister, call the cops, I don't care. I will tell them that you don't know how to take care of me. You make me want to hurt myself."*

At the end of the report, it is recorded that after the restraint was finished, he was required to "complete his NSTO (non-seclusionary time out)" and then to complete his quiet time before rejoining the activities.

FOOD

Upset over concerns related to food and mealtimes appear as a reoccurring theme in the SORs. There were 194 SORs that were precipitated by issues around mealtimes or food. One report was a *Type #2: Serious Injury*, reporting that a child had refused to eat for many days. Five SORs reflected complaints made by young people about the quality and quantity of food. One allegation of abuse was investigated by a CAS over reports of inadequate quantity of food.

The remaining 188 occurrences related to physical restraints that occurred surrounding concerns about food or during meal times. These 188 occurrences account for 8% of the SORs about restraint and 10% of the restraints of young people with or suspected of having a developmental disability. It should be noted that there are some residences that require young people to remain in their rooms while meals are prepared. This is sometimes known as "quiet time." A number of the restraints reported around food were in the context of young people struggling to remain in their room as they wait for their meals.

> *"At 10:15 during snack time, Zack was asked to go and get his healthy snack. His 1:1 asked him to eat his fruit first then have his cookies at lunch; Zack insisted that he wanted his cookies first. Staff B reminded Zack that he is to eat his Clementine first because it is healthy. He began to display aggressive behaviours and he threw his fruit against the wall. Staff quickly physically prompt[ed] Zack (as per his safety plan) and transitioned him to [the] problem solving room."*

THE LANGUAGE OF "CARE"

At times, the language used in these reports appeared harsh and punitive. Recall that none of these reports are about young people in a youth justice facility, yet there is frequent reference to young people "serving restitution time," "dropping levels" and "doing quiet time." There were 362 references to AWOL. Language characterized as "harsh" includes statements such as: "staff going hands on," "take downs" and "walk by take downs." There is also the use of institutional language such as "EBT" (early bed times), "quiet time" and "off program." In addition, the generic term "staff" is frequently used instead of naming individuals or describing their position in the organization.

DISCUSSION ON LACK OF VOICE, EMOTIONAL UPSET AND THE LANGUAGE OF CARE

The SORs detail incidents in which young people experienced considerable loss and upset. Most striking, is the absence of their voice. The language of the care system is stark. The reports are full of acronyms, euphemisms and unusual descriptors.

It is important always to keep in mind that the situations being discussed involve vulnerable young people, including some of Ontario's most vulnerable, entrusted to the care of others. These young people — many of whom have experienced loss and trauma or have other behavioural, cognitive or emotional challenges — lack the developmental capacity to fully regulate their emotions and behaviours. Their distress is often demonstrated behaviourally and their actions express what their cognitive immaturity prevents them from communicating.[88] Their distress is described in these reports, offering a window into a serious situation in children's residences.

It is important to consider that some of the children in residential care live in situations where they have little access to the outside community. That is, they both live and go to school at the residence and engage in little activity that is not fully supervised by staff from the residence. These young people may also be far away from family members and the workers from a children's aid society or other placing agency that are responsible for them. This finding is compounded by some of the harsh language found in the reports, which reflect the type of care provided to young people. As noted earlier, the *Searching for Home* report identified concerns that young people in care who did not feel safe often did not report this to anyone because they were not sure how to do so. Currently, only SORs about physical restraints are required to include the view of the young person, and even this was not done in 59% of the reports reviewed.

In order to enhance safeguards to young people in care, the view of the young person should be required as part of the serious occurrence reporting process for most categories of serious occurrence. The idea that a person external to the children's residence should be responsible for obtaining the view of the young person is one that should be seriously considered. Alternatively, young people might be provided with other methods to register their viewpoints such as a dedicated telephone line to a ministry licensing office or computer access to file their own version of the incident directly with MCYS.

88 Marusak, H.A., Martin, K.R., Etkin, A. and M.E. Thomason (2015). Childhood trauma exposure disrupts the automatic regulation of emotional processing. Neuropsychopharmacology, 40, 1250-1258.

11. CONCLUSION AND RECOMMENDATIONS

SORs have the potential to act as an early warning system. This review demonstrates "proof of concept" that the rigorous analysis of these reports gives a useful early indicator of concern and provides benchmarks to ensure compliance with standards. Looking at the data in this way allows for the identification of points of concern, unusual situations, and trends in practice. For example, this review was able to point to a theme at some facilities whereby the child's view of the restraint was not recorded based on a decision made by the service providers. While there may be times where debriefing may be counter indicated for an individual child, it is in fact a legal requirement to do it. When this phrase is repeated in most — if not all — SORs at a facility, it should be possible to detect this type of trend and to take action.

Some other examples of patterns that can be identified from these SORs are:

- 25 agencies report 80% of the SORs about physical restraint
- 315 agencies did not submit any SORs
- 37% of SORs about physical restraint are about young people known to or suspected to have a developmental disability

Each of these findings, obtained by a simple counting of the SORs, should prompt those with legal oversight responsibilities to take a closer look. A high number of restraints or SORs alone may not be cause for concern, as the agency may be adhering closely to the Ministry reporting requirements. However, if closer review finds that reports are not completed fully, lack justification for the restraint, and omit the voice of the child, action is needed.

The deeper analysis done for this review allowed for the detection of other areas of concern such as:

- Multiple ways of reporting medication errors
- Lack of clear reporting lines for victimization
- Inconsistent reporting of injuries including those proximal to restraint

THE NEED FOR STANDARDIZED REPORTING

Inconsistent reporting results in confusion and obscures the true rates of medication error, victimization and injuries. When a child is in the care of others, it is particularly important to clearly red flag any situations of risk and victimization so that the true rate of these types of occurrences can be determined. Establishing clarity about reporting these situations would help to determine if the care system is providing a safe environment, and prompt corrective action when necessary.

There is a need for more guidance about what constitutes the complete and consistent reporting of a serious occurrence. Few reports were fully completed and most lacked information that included the young person's voice even where it was required to do so. There are certain types of situations that were often reported inconsistently under different occurrence types and these included situations such as victimization, medication errors, motor vehicle accidents and injuries or allegations of abuse from restraints.

Victimization by assault or sexual assault is not directly captured as a distinct category in the SORs. As mentioned earlier, without a consistent mechanism to capture all instances of victimization, a true victimization rate is impossible to determine. The researchers had to resort to collating three SOR types (*Type # 3: Alleged, witnessed, suspected abuse, Type #2: Serious injury to a client* and; *Type #7 Complaint made by or about a client, or other serious occurrence involving a client*) to obtain an estimate of the rate of victimization in residential care. This current SOR method of reporting victimization by assault or sexual assault is unacceptable.

YOUNG PEOPLE WHO GO MISSING

A province wide discussion is needed to consider what must be done in situations where children are considered to be missing from a children's residence. As demonstrated in the findings, there are at least three different risk profiles of young people who went missing ("out for the night," "did not wish to return," "extremely high risk"). Residential care providers need a way to provide a differential response to the different risk profiles so as not to inadvertently criminalize young people in residential programs. A risk assessment checklist, similar to the one used in British Columbia or the modified version described earlier in this report, is a tool that could be immediately implemented in advance of a province wide discussion to generate a consensus based toolkit. This is another example of the need to modify the SOR form to include a place on the form for the young person to describe why they left, if they have concerns, or if they would like to have a health care practitioner follow up with them.

SIBS & DSH (NSSI)

There is high rate of Deliberate Self-harm (DSH)/NSSI (Non-Suicidal Self-Injury) and Self-Injurious Behaviour in these reports. There are few mentions of protective apparatus to reduce the harm to individuals engaged in SIBS. The use of injury prevention strategies for SIBS may be more widespread than can be gleaned from the SORs, but this review points to the need for further information about the extent to which protective equipment, environmental modification, and injury prevention strategies are considered and implemented with this population of young people.

DISABILITY

Slightly more than a quarter (27%) of all SORs, and more than a third of SORs (37%) about physical restraints relate to young people with an identified or suspected disability. This is an underestimate of the prevalence of disability in children's residences because some disabilities are invisible, or the existence of a disability may not be perceived as relevant to the report. Young people with communication or developmental disabilities are safeguarded through external review of their care because it is difficult for them to raise an alarm when something is not right. Therefore, oversight bodies have an enhanced duty to vigilantly scrutinize the care of these young people.

ADVANCING THE SAFE PRACTICE OF PHYSICAL RESTRAINT

There is a clear need to have a robust review and reconsideration of the way physical restraints are used in Ontario. This review finds an average 40 restraints are used in a children's residence in Ontario every day. Most of the restraints are used in a small number of agencies, with 25 residences accounting for 80% of the reports. It was generally very difficult to determine what less intrusive measures were used prior to applying physical restraint. In only 56% of the SORs about physical restraint was the imminent threat readily apparent from the report. More research is needed that focuses on the degree to which the restraints are applied in a way that is consistent with the training. It remains unknown if any particular method has a higher injury rate than others and there is no readily available data to compare the various approved restraint methods.

An oversight committee should be comprised of individuals who have prerequisite education in child development, as well as experience and education in Child and Youth Care, Social Work, Psychology, Nursing, Kinesiology and Psychiatry to assess the safety of the restraint on young people. Along with education, committee members should have experience directly related to working with children with developmental and communication disabilities, trauma, behavioural and mental health concerns. The committee should be charged with conducting research, establishing best practice methods and alerting the field to new knowledge and trends.

VOICE OF THE CHILD

The most striking finding in this review is the lack of attention to the voice of young people in these reports. The experience of the children whose physical and emotional well-being is at the centre of the events documented in these reports is noticeably missing. The blank and N/A comments in the person's view section of the SORs about *Type #8: Restraint of client* are telling. The omission of this information, especially in situations where it is clearly required, renders vulnerable children voiceless. This is unacceptable when young people are subject to intrusive physical intervention by adults, and particularly troublesome in those reports where the legal justification to use a physical restraint has not been clearly documented.

Direct reporting by the children involved in the occurrence is absolutely necessary to get a full picture of the events being reported. Currently, the view of the young person is only legally required for reports about physical restraint and, even then, this is often missing. This must change. At minimum, it should be legally required that the viewpoint of the child be sought out and documented for each type of serious occurrence. Another option would be for either the Ministry or the placing agency receiving the report to be legally required to call the child or have a mechanism for the child to call in and report their perspective of the event.

AGENCY-LEVEL NOT JUST INDIVIDUAL LEVEL, OVERSIGHT

People who place children have the responsibility to read, review and ask questions about every SOR they receive; however, it is apparent that a number of residential programs accept children from several different placing agencies. Each placing agency may have only one or two children at the residential program. As such, no one placing agency has the capacity to provide a comprehensive level of oversight because each placing agency is only privy to the concerns raised by the specific individual in care, not of all of the residents in the residence. Issues identified by the placing agencies should be reported to the children's residence and to the Ministry.

Service providers and governments should undertake regular review and analysis of these reports to identify trends and patterns and to determine ways to enhance safeguards. While SORs have been criticized by some as needlessly increasing the administrative burden to agencies, this review demonstrates that they yield useful and crucial information about the care system.

RECOMMENDATIONS:

SOR FORM

1. Redevelop the form:
   - **A.** Record victimization including peer on peer violence.
   - **B.** Ensure all police services contact is recorded in a distinct location with the reason for contact described.
   - **C.** Create a specific section in which all medication errors are to be recorded.
   - **D.** Create a specific section on the form in which all serious injuries are to be recorded.
   - **E.** Create a specific section on the form in which to record any other injury sustained during a serious occurrence.
   - **F.** The guidelines should require that the viewpoint of the child is sought.
   - **G.** Create a specific section and require service providers to articulate the "imminent risk" that justifies the use of a physical restraint.
   - **H.** Include a place under the section on "missing children" that prompts staff to inquire about and record: why the child left, what happened while they were away, if medical care required, and what could be done to prevent them from leaving again.
   - **I.** Create a specific section to flag Communication and Intellectual disabilities as an indicator of that child's potential vulnerability.

TRAINING

2. MCYS should embark on a province wide training to ensure that all service providers are aware of their responsibilities to fully and completely report serious occurrences.

ONLINE PORTAL

3. Create an online reporting portal in order to reduce the following problems: illegible reports, service providers using multiple versions of the form missing and incomplete information.

ROLE OF POLICE AT CHILDREN'S RESIDENCE

4. Ensure that a SOR is filed for each and every police contact.
5. Gather data to accurately ascertain the rate of police attendance/involvement in children's residential services.
6. Ensure that all police engagement with children's residences is consistent with legislation and best practices.

YOUNG PEOPLE WHO GO MISSING

7. Create a mechanism for responding to differential risks faced by missing children through a province wide discussion that includes police, service providers, and residential service providers.

CHILDREN FAR FROM HOME

8. MCYS should track the number of children receiving services from out of province, or more than 300 km from their home community.

DSH (NSSI)/SIBS

9. MCYS should ensure guidance is provided to the field about:

- **A.** The difference between DSH(NSSI)/SIBS.
- **B.** Injury prevention strategies and apparatus for managing SIBs.

RESTRAINT

10. When documenting the incident, there is a need for clear and descriptive reporting that presents an unambiguous and distinct description of the events from the perspective of the people applying the restraint.

11. The people employing the restraint must articulate their perception of the imminent risk using clear and descriptive language relating specifically to the event being reported.

12. The young person must be provided an opportunity to directly provide their description of the events from their perspective.

13. A panel of experts to be formed, with appropriate education in child development, to assess and approve restraint methods and to commission research to evaluate the safety and effectiveness of approved restraints.

14. All approved training programs should identify the potential risks associated with restraint including asphyxiation, chest/shoulder compression and injury to limbs and joints (including wrists).

15. All approved training programs reflect on the language used when describing restraints when used with vulnerable children.

16. MCYS and MCSS should ensure that all approved restraint methods undergo routine evaluation to ensure the safety of the method and fidelity to the technique, given that the "Train the Trainer" model is in place in Ontario.

17. MCYS and MCSS should fund research to better understand the risks associated with the use of physical restraint on young people and those with developmental disabilities.

18. CYC programs at both the college and university level should review the curriculum to enhance skills in therapeutic activities with children, crisis de-escalation strategies and trauma informed care and foster an ethic of lifelong professional development.

19. Child and Youth Care programs, offered by colleges and universities, must teach alternatives to restraint and fully educate future practitioners about the risks of harm from physical restraint.

DUTY TO SAFEGUARD

20. Every individual receiving SORs about a child in care must read the report, assess whether they have a full understanding of what occurred, compare what is written to standards and guidelines, ensure the young person's voice has been sought and that the child is currently safe, and follow up for more information when anything is unclear.

21. Placing agencies, children's residential service providers, and MCYS should collate data from SORs to identify issues of concerns, trends, and service patterns.

22. Placing agencies should report any issues of concern to MCYS promptly.

23. In the aggregate, this data should be publicly reported to allow for province wide comparison of trends, service usage and issues of concern.

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