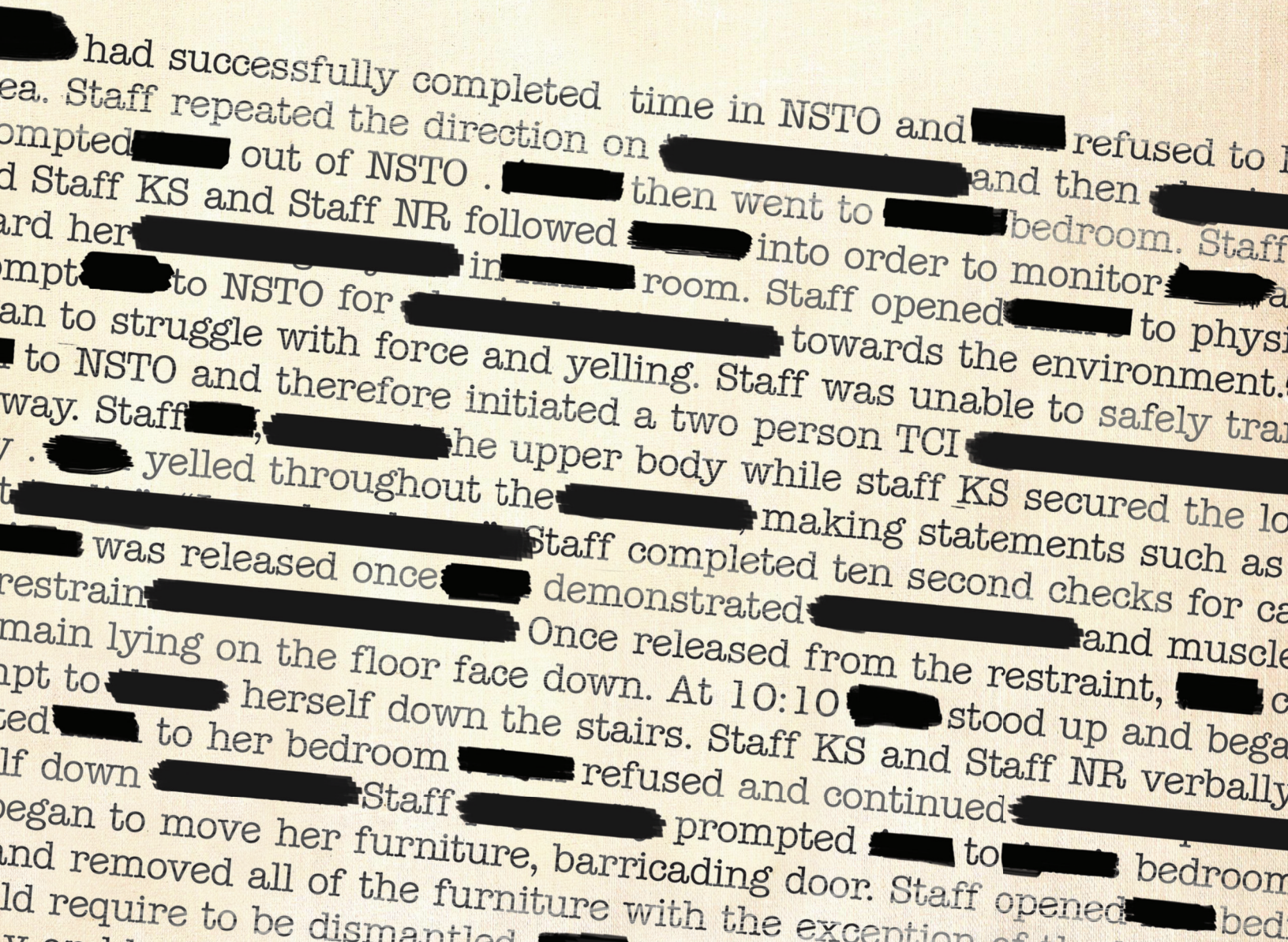
Provincial Advocate
*for* Children & Youth

# SERIOUS OCCURRENCES REPORT

## Preliminary Report

February, 2016



# Serious Occurrences Report

## Preliminary Report
## February 2016

Office of the Provincial Adovocate
for Children and Youth

Dr. Kim Snow, Ryerson University

Provincial Advocate *for* Children & Youth



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

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# A: OVERVIEW

Some of the things that happen in children's residences[1] are deemed to be of such significance that, when they occur, must be reported to the Ontario government within 24 hours. These incidents are known as "serious occurrences" and notification is made to the government by means of a *"Serious Occurrence Report"*. To understand more about the types of serious occurrences that are reported across the province and how often these events take place, the Office of the Provincial Advocate for Children and Youth ("Advocate's Office") examined serious occurrences, submitted to the Ministry of Children and Youth Services ("MCYS"), during the first three months of 2014.

The purpose of this report, which is characterized as a "review" under section 16(1)(p) of the *Provincial Advocate for Children and Youth Act, 2007*,[2] is to gain a better understanding about the degree to which *Serious Occurrence Reports* function as a safeguard for children and youth. We began our work with the assumption that the *Serious Occurrence Reports* should contain enough information to identify situations of concern and alert those with oversight responsibilities to patterns or trends that might impact upon the safety and well-being of young people in the residential care system. It should be noted that this is an interim report, created to provide information to the MCYS Residential Services Panel prior to the completion of their work. It is important to keep in mind that this report is a

The purpose of this report... is to gain a better understanding about the degree to which Serious Occurrence Reports function as a safeguard for children and youth.

descriptive analysis of the events recorded in the serious occurrence reports rather than an assessment of the overall quality of care provided in a specific residence. What this means is that the intent is to understand what happened before, during and after the serious incident and whether or not what was recorded meets the legislative and policy framework in existence at the time of this writing. A more detailed analysis, including a closer look at *Serious Occurrence Reports* related to the use of physical restraints, self-harm, and missing children, will be released in the coming weeks.

The preliminary conclusions based on the review of 5,011 Serious Occurrence Reports are two-fold:

1. The quality of the *Serious Occurrence Reports* submitted to MCYS is often quite poor and reduces the effectiveness of the report as an 'early warning system' or safeguard.
2. The format of the existing *Serious Occurrence Reports* is confusing and obscures information about the frequency and nature of certain types of incidents.

[1] The definition of a "children's residence" can be found in section: C. METHODOLOGY OF REVIEW
[2] Provincial Advocate for Children and Youth Act, 2007 S.O. 2007 c.9 as amended

# OFFICE OF THE PROVINCIAL ADVOCATE FOR CHILDREN AND YOUTH

The Office of the Provincial Advocate for Children and Youth 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 prompt action on their issues.

Due to their age, dependency status and separation from natural advocates, it is often difficult for children and youth to champion their own interests.

The Advocate's Office derives authority from the *Provincial Advocate for Children and Youth Act, 2007*.[3] In response to a request, complaint, or on its own initiative, the Advocate's Office acts on behalf of individuals or groups of children and youth and can undertake reviews (defined as "gathering and assessing information"), make recommendations, and provide advice to governments, facilities, agencies, or service providers. The scope of the authority to conduct reviews includes the power to review facilities, systems, agencies, service providers, and processes.

## THE IMPORTANCE OF SAFEGUARDS

Children living away from their family may be isolated and vulnerable, regardless of the reason they entered the care system. Some of these young people were removed from their families, and deemed to be "in need of protection". Other youth may be in need of residential services, either on a temporary or permanent basis, because their needs outstrip the ability of their parents to provide specialized care. When these children are placed at great geographic distances from their home communities; have been moved repeatedly while in the care system; are long term residents of an institution; or are simply not doing well, extra safeguards are required. This is especially true if the young person is not under the ongoing supervision of a parent (or parent-like figure) with the ability to ensure that their interests are properly protected and their needs are met.

The notion of safeguards for children in residential care is not a new one. In December 1990, the Ontario Government released a report entitled, "Review of Safeguards in Children's Residential Programs" ("Safeguards Report"). The review dealt with the adequacy and effectiveness of the measures intended to protect young people against physical, sexual, and emotional abuse and assault, and to ensure that if allegations of abuse or assault were made, there were systems in place to deal with them in a responsive and effective manner.[4] The report was part of a larger response by the provincial government to allegations of abuse in government-funded training schools in the 1960's.[5]

[3] Provincial Advocate for Children and Youth Act, 2007, SO 2007, c.9

[4] Joanne Campbell, Review of Safeguards in Children's Residential Programs: A Report to the Ministers of Community and Social Services and Correctional Services (Toronto: Queen's Printer for Ontario, 1990) at 3.

[5] Joanne Campbell, Review of Safeguards in Children's Residential Programs: A Report to the Ministers of Community and Social Services and Correctional Services (Toronto: Queen's Printer for Ontario, 1990) at 1

In considering what makes children safe in residential care, the authors of the report identified the existence of legislated safeguards for children in 'out of home care': These include:

- the ban on corporal punishment and the limitations on the use of force by service providers
- the right of residents to communicate with their families, the Advocate's Office, the child's legislative representatives
- the existence of internal complaints procedures and further external reviews/appeal mechanisms
- the requirement that young people be informed of their rights
- the availability of a complaints procedure; approved methods of discipline and intervention
- that children, youth and staff are empowered to make complaints without fear of reprisals and
- that all serious occurrences, including serious complaints made by a resident, or the injury of a resident by a staff person or foster parent, must be reported to MCYS[6]

Due to their age, dependency status and separation from natural advocates, it is often difficult for children and youth to champion their own interests, especially when they are in the care of the state or receiving 24/7 services from the government. When children do not have the ongoing protection of their parents, additional safeguards are necessary. For this reason, every possible tool should be utilized to its fullest potential to protect the safety rights, and best interests of those in residential care.

[6] Joanne Campbell, Review of Safeguards in Children's Residential Programs: A Report to the Ministers of Community and Social Services and Correctional Services (Toronto: Queen's Printer for Ontario, 1990) at 27

# B: OVERVIEW OF SERIOUS OCCURRENCE REPORTING IN ONTARIO

## ABOUT SERIOUS OCCURRENCE REPORTS

Regulation 70 of the *Child and Family Services Act* requires residential service providers to notify a parent, the Ministry of Children and Youth Services, and those responsible for the placement of a child in a particular residential facility (such as a children's aid society or other agency), in the following circumstances:

- Death of a child
- Serious injury of a child
- Injury of a resident by staff person or licensee
- Abuse or mistreatment of a child
- Physical restraint of a child
- A complaint of a serious nature is made by or about a child
- A fire or other disaster occurs on the premises
- Any other serious occurrence concerning a child takes place

In addition, the regulation requires police to be notified and reports to be completed when a resident is "absent without permission" from a residence for more than 24 hours, or absent without permission for less than 24 hours if the absence is considered by the licensee to be a serious matter.[7]

## OUTLINE OF THE SERIOUS OCCURRENCE REPORTING PROCESS

Expectations of the Ministry of Community and Social Services and the Ministry of Children and Youth Services are set out in the Serious and Enhanced Serious Occurrence Reporting Guidelines (2013) that spell out the necessary steps for notifying the Ministry that one of the designated types of incidents have occurred. These are:[8]

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 7 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.

In addition, service providers are also required to submit an *Annual Summary and Analysis Report* to the local Ministry Regional Office. The purpose of the report is to summarize the agency's reports over the year and identify issues, trends, patterns and actions taken. This report is then reviewed by a Regional Office, at which point situations that require follow up, training or support are expected to be identified and communicated to the service provider.[9]

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7 R.R.O. 1990, Reg. 70, s 102.

8 Ministry of Community and Social Services, Ministry of Children and Youth Services, Serious and Enhanced Serious Occurrence Reporting Guidelines, (March 2013).

9 Ministry of Community and Social Services, Ministry of Children and Youth Services, Serious and Enhanced Serious Occurrence Reporting Guidelines, (March 2013) at p13.

# C: METHODOLOGY OF REVIEW

The focus of this review is to examine the extent to which *Serious Occurrences Reports* function as an effective safeguard for children in care. Individual *Serious Occurrence Reports* were reviewed to see if it could be determined what happened before, during and after the serious incident.

The term "children's residence" is defined by the *Child and Family Services Act* and includes a foster home, another home or institution operated by a children's aid society, a "parent model" group home, a "staff model group home" and youth justice placements such as temporary detention, "open" or "secure" custody.[10] In addition to child welfare and youth justice placements, the residential service providers funded, operated, licensed, or approved by the Ministry of Children and Youth Services include those who offer residential care for children and youth with special needs, developmental disabilities, require palliative care, or who require out of home respite care. According to MCYS, there were 16,037 licensed children's residential beds on March 31, 2014. In response to questions posed by the Advocate's Office, MCYS indicated that 20,429 *Serious Occurrence Reports* were filed in the calendar year 2013 (excluding youth justice facilities). Subsequently, all *Serious Occurrence Reports* filed by children's residences were requested for the period of January 1 to March 31, 2014. A total of 5,011 *Serious Occurrence Reports* were received from MCYS in September 2014.

The data was provided in PDF format according to the Ministry Region with several hundreds to over a thousand forms per PDF. These PDFs were then split into individual forms and processed through an optical character recognition software program. In approaching the data the following questions were explored: What happened? What led up to it? What was done?

In addition, we met with service providers to discuss serious occurrence reporting, identify their concerns and seek consultation on how to interpret the data.

Data was processed through a two-step entry and coding system to ensure accuracy and consistency of coding. All information reported on the serious occurrence form was entered into a spreadsheet. Although gender was redacted on the *Serious Occurrence Reports*, we were often able to determine gender. Two human coders reviewed each SOR and gathered specific information based on the category of serious occurrence. The 2013 MCSS/MCYS Serious and Enhanced Serious Occurrence Reporting Guidelines were used to generate yes / no codes with the aid of the data analytic software program CaseMap. Codes were data driven rather than interpretive, meaning the codes were based on variables such as the name of restraint used, identified cause of death, or the specific complaint made, rather than our own interpretation of events. As an example, for serious injury we used the code medication error and the seven listed sub-codes that are provided in the guidelines. In addition to the 'within category' codes, environmental factors such as the occurrence happening in a vehicle, outside of the residence or involving emergency service personnel were also coded. For other categories such as restraint, the seven items that must be described were created as codes. For category 7: complaint by or about a client or other serious occurrence, additional descriptive codes were created to capture the variety of incidents captured as 'other'. In most cases, these codes existed in other categories and were applied to this analytic set. All of the *Serious Occurrence Reports* were coded as "yes", "no" or "unsure" to determine if the child had a developmental disability. The category "unsure" was added to cover cases where it was evident that due to the descriptor or the specialization of the home that the young person likely had a developmental disability. The reading of the reports and the coding of descriptors were determined by the primary questions of this analysis: What happened? What led up to it? What was done? The interim report and the forthcoming final report provide a descriptive analysis of the findings.

It is important to note that these are preliminary statistics and the data is likely to change as we integrate new reports and remove duplicates. However, we are confident that the general trends are accurate and the analysis provided gives a good snapshot of the nature and types of serious occurrences that took place during this time period.

[10] Child and Family Services Act RSO 1990 c. C. 11 s 192

## REDACTED INFORMATION

While it was anticipated that the names of the children and youth involved in these incidents would be redacted, the gender and date of birth of the young people involved was also redacted despite a specific request for that information from the Advocate's Office. MCYS cited "privacy" concerns as the reason. Information about medication was also often redacted, sometimes even when a medication error was the reason why the *Serious Occurrence Report* was submitted. In other situations, lengthy passages of information were redacted for reasons that are not immediately clear. Examples of this type of unexpected redaction typically relate to the details of serious mental health crises. These redactions make it difficult to understand the nature of serious incidents and how often young people are medicated in the context of a crisis situation. Similarly, redacting the date of birth has the effect of obscuring the frequency with which intrusive measures are used against extremely young children.

In another case example unrelated to the current review of *Serious Occurrence Reports*, the Advocate's Office had been unaware after reviewing redacted *Serious Occurrence Reports* that a particular residence frequently used physical restraints on children ten-years of age. The situation came to light once the children themselves contacted the Advocate's Office.

It is imperative that information provided to the Office of the Provincial Advocate for Children and Youth be unredacted and complete to enable the Provincial Advocate to understand the full circumstances and context of incidents related to children within the Office's mandate. Any concerns that information received by the Provincial Advocate would not be subject to privacy protections can be addressed quite easily by reference to section 20 (10) of the *Provincial Advocate for Children and Youth Act, 2007* which prohibits the Advocate's Office from disclosing in a public report or public communication the name or identifying information of any individual who has not consented to such disclosure.

While the Advocate's Office has been granted investigative powers under the *Public Sector and MPP Accountability and Transparency Act* (known as Bill 8) which will be proclaimed March 1, 2015, it is important to note that these powers will permit the Office to conduct investigations and compel non-redacted information from service providers in only one area of the mandate: children receiving services from a children's aid society or a residential licensee funded as a children's aid society placement.

Therefore, many young people within the mandate of the Advocate's Office are excluded from the added protection offered through Bill 8, including young people in youth justice facilities, homes for children and youth with special needs (including those with developmental disabilities), children's mental health centres or palliative care home when placed by a parent. As will be discussed below, there were more than 800 serious occurrences related to children and youth who were not in the care of a Children's Aid Society during this three-month period. In these situations, the Advocate's Office does not have the legal authority to compel information from a service provider beyond that which may be available to any member of the public through an access to information request under the *Freedom of Information and Protection of Privacy Act*.

## PURPOSE OF THE INTERIM REPORT

The purpose of this interim report was to inform the work of the Residential Services Panel ("the Panel") established by the Ministry of Children and Youth Services and tasked with the review of all sectors of the child and youth residential service system. The Panel is expected to deliver their final report by the end of February 2016.[11]

[11] Ministry of Children and Youth Services, "Residential Services Panel Terms of Reference", online: Ontario Ministry of Children and Youth Services <http://www.children.gov.on.ca/htdocs/English/topics/specialneeds/residential/panel-terms-of-reference.aspx

# D: RESULTS FROM DATA

## TYPES OF SERIOUS OCCURRENCE REPORTS

When completing a Serious Occurrence Report, all incidents are classified into one of eight categories of serious occurrence types by the reporting agency. Several of those categories are then divided into sub-categories, which may also be further divided into sub-categories. Any serious occurrence that might happen to children in residential care is categorized as one of the following:

1. *Death*
2. *Serious Injury*
   - caused by service agency
   - accidental
   - self-inflicted / unexplained
   - medication
3. *Alleged, Witnessed or Suspected Abuse*
4. *Missing Person*
5. *Disaster on the Premises*
6. *Complaint about Operational, Physical, or Safety Standards*
7. *Complaint Made by or About a Client or any Other Serious/Enhanced Serious Occurrence Involving a Client*
8. *Restraint of Client*
   - those who have developmental disabilities
     + crisis situation
     + challenging behaviour and resulted in injury
     + challenging behaviour and resulted in an allegation of abuse
     + mechanical restraint
   - all other restraints
     + no injury
     + resulting in injury
     + allegation of abuse

In practice, restraints on children with developmental disabilities are sometimes mistakenly coded in the section meant for adults with developmental disabilities. As will be discussed later in this report, several types of situations (such as allegation during restraint or medication error) are reported using different categories.

To date, there are 5,011 reports and we have determined there to be 4,839 distinct incidents. The Advocate's Office is confident with these numbers, although minor variation is expected as the additional reports will either confirm these numbers or identify further duplicates. It is also expected that additional incidents will be found in the new data. This interim report is based on the 4,839 distinct incidents currently identified with the expectation that these numbers are preliminary and will change in the final report (as the new data is included and further duplicates removed).

### *SERIOUS OCCURRENCE REPORT BY TYPE*

Nineteen deaths occurred in this three-month time period. None of these deaths were reported as homicides. In this sample, serious injuries were reported at an average of 3.71 per day. Many of the serious injuries relate to self-inflicted injury or mental health crisis, others include sports injuries or other injuries common in childhood (sprains, bruises and cuts).

There were 116 reports of alleged, witnessed or suspected abuse. Allegations against staff and foster parents account for 32.14% of incidents. Allegations about family members related to 30.36% of reports. Allegations of abuse during restraint account for 13.39% of those reported in the *Category 2: Alleged, Witnessed or Suspected Abuse*. Allegations of abuse are also reported in *Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client*.

There were 944 reports of missing young people. In most cases, the young person returned to the program of their own volition. Missing person incidents are most likely to result in a series of reports to MCYS. As of the last report filed by the service provider in the time period under review, the location of the young person was still not known in slightly less than a third of the incidents.

*Category 5: Disaster on Premises* includes any incident that disrupts or endangers the residence or interferes with daily routines. This would include things such as fire, flooding, infectious disease or threats to the residence. There are 16 reported incidents of disaster on the premises.

*Category 6: Complaint About Operational, Physical, Safety Standards* includes reports of adverse water quality, hazardous or dangerous substances, medication error that does not result in injury/illness, missing or stolen files and neighbor complaints. There were 46 reports of this nature identified through our analysis.

*Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client* includes police involvement, serious assaults, hospitalization, inappropriate discipline or complaints arising from sexual contact between clients. This is the second largest category, with 1,010 reports. Medical crises, which include both physical health and mental health, account for 31.58% of reports.

In this sample, serious injuries were reported at an average of 3.71 per day.

Reports on *Category 8: Restraint of Client* is the largest category with 2,354 reports. Of these, 568 incidents of restraint were identified in which a child was known to have a developmental disability. In another 169 instances restraints were used on a child with suspected developmental disabilities or other communication barriers (either because it is recorded that the child is nonverbal or the residence specializes in serving children who have developmental disabilities). Taken together, restraints were used on a child with a known or suspected developmental disability in 737 reports. These numbers suggest that 31.31% of reported physical restraints were used on children and youth who have or likely have developmental disabilities.

### TABLE 1: SERIOUS OCCURRENCE BY TYPE

| | NUMBER OF INCIDENTS |
|---|---|
| Death | 19 |
| Serious Injury | 334 |
| Alleged, Witnessed or Suspected Abuse | 116 |
| Missing Person | 944 |
| Disaster on Premises | 16 |
| Complaints About Operational, Physical or Safety Standards | 46 |
| Complaints Made by or About a Client, or Other Serious Occurrence Involving a Client | 1,010 |
| Restraint of Client | 2,354 |
| Blank, Excluded, or Disregarded Duplicate | 172 |
| **TOTAL** | **5,011** |

## *OUT OF PROVINCE*

Children from outside of Ontario are sometimes placed in Ontario children's residences to obtain care that they are not able to receive in their home province or territory. Typically, the originating location enters into an agreement with a local (Ontario) Children's Aid Society to oversee the placements. The agency from the home province may also make arrangements directly with a service provider for placement without the involvement of an Ontario Children's Aid Society.

A total of 33 occurrences involving young people from outside of the province who had been placed with a residential service provider in Ontario were identified. Most of the young people were in Ontario to receive children's mental health services. Several were medically fragile and receiving specialized medical foster care.

### *TABLE 2: CHILDREN FROM OUT OF PROVINCE BY CATEGORY OF SERIOUS OCCURRENCE REPORT*

| | NUMBER OF INCIDENTS |
|---|---|
| Death | 0 |
| Serious Injury | 1 |
| Alleged, Witnessed or Suspected Abuse | 3 |
| Missing Person | 2 |
| Disaster on Premises | 0 |
| Complaints About Operational, Physical or Safety Standards | 1 |
| Complaints Made by or About a Client, or Other Serious Occurrence | 6 |
| Restraint of Client | 20 |
| **TOTAL** | **33** |

Serious Occurrence Report Guidelines require that the parent, guardian or the authority responsible for placing the child be notified of any incident significant enough to warrant a *Serious Occurrence Report*. Given the geographic distance from their home, reports were reviewed to determine who was notified when serious incidents occurred. It was noted that the home province or territory was alerted in the majority of situations and, in 6 incidents, the local Ontario agency was notified. The local agency may have in turn notified the home community, but the lack of indication on the form of this notification provides little ability to trace such notification or catch lapses in communication.

### *TABLE 3: NOTIFICATION OF SERIOUS OCCURRENCE*

| | NUMBER OF INCIDENTS |
|---|---|
| Parent | 1 |
| Local (Ontario) Children's Aid Society | 6 |
| Provincial or Territorial Authority | 26 |
| **TOTAL** | **33** |

### *NOTIFICATION TO OUT OF PROVINCE AUTHORITY WHEN ABUSE ALLEGED*

There were three situations when children from another province made allegations of abuse. Two of these incidents relate to allegations of abuse while "in care". In one case a staff person was the alleged perpetrator of the abuse, in the other case a peer was the named abuser. The reports indicated that in each of these cases the home province was notified.

## WARDSHIP/GUARDIANSHIP STATUS

Reports indicate some information on the guardianship status of young people such as the care status of "Crown Ward", "Society Ward" and "Temporary Care Agreement". In some instances, a children's aid society was identified as the guardian for the child and no further specification is provided.

Twenty-one incidents relate to situations that involve more than one child. Children in parental care account for 16.8% of reports. In the majority of incidents, the children had involvement with a children's aid society. In 140 cases, no indication was given whether the particular child or youth was involved with a children's aid society or was in parental care as there was no indication that a guardian was notified or this information was redacted.

### *TABLE 4: WARDSHIP/ GUARDIANSHIP STATUS*

| | NUMBER OF INCIDENTS |
|---|---|
| Report Relates to Group of Young People Not an Individual | 21 |
| Parental Care | 813 |
| Crown Ward | 397 |
| Children's Aid Society is the Guardian* | 3,174 |
| Society Ward | 223 |
| Temporary Care Agreement | 69 |
| Unknown | 140 |
| Adopted | 2 |
| **TOTAL** | **4,839** |

* A children's aid society was identified as guardian but not further specified

# BREAKDOWN OF SERIOUS OCCURRENCES

## CATEGORY 1: DEATH

The first category of serious occurrence is death of a child. The guidelines require that a report be submitted on the death of any child participating in service or receiving community-based supports funded or licensed by MCYS or MCSS, or receiving services from a Children's Aid Society at the time or in the 12 months immediately prior to the death.

There were nineteen deaths of children reported from January 1 to March 31, 2014 — none were homicides. Of the two suicides reported, one young person was on the waiting list for mental health services and the other was receiving mental health services. There were four cases reported as S.U.D.I. meaning: "sudden unexplained death of an infant". Disability/obesity is a factor in the deaths of two young people. In one case, a young person died unexpectedly while receiving medical treatment.

In the four situations of palliative care, the deaths were reported using the exact same phrase: "Patient died due to illness. Death expected". Six medically fragile children died. In two of those six cases, children died unexpectedly from complications due to an acquired illness. In two further cases, medical intervention was discontinued. In one of these situations where the child was a ward, it was not clear if there was a third party review of this decision, such as by a disability guardian or a medical ethics review board. In two additional cases, young people who were wards of the state had "do not resuscitate orders" and were not resuscitated at the hospital.

### *TABLE 5: DEATH OF CHILDREN*

| | NUMBER OF INCIDENTS |
|---|---|
| Suicide | 2 |
| Palliative | 4 |
| Medically Fragile | 6 |
| "Sudden unexplained death of an infant" | 4 |
| Disability / Obesity | 2 |
| Unexpected other | 1 |
| **TOTAL** | **19** |

### *WARDSHIP/ GUARDIANSHIP OF CHILDREN WHO DIED*

In the majority of cases where a child died, there was no indication of children's aid society involvement noted on the *Serious Occurrence Report* and it is assumed that guardianship rested with the parents in these twelve cases. Six of the children who died were Crown Wards. In one case it was not possible to determine the status of the child.

### *TABLE 6: WARDSHIP/ GUARDIANSHIP OF CHILDREN WHO DIED*

| | NUMBER OF INCIDENTS |
|---|---|
| Ward | 6 |
| Unknown | 1 |
| Parental Care | 12 |
| **TOTAL** | **19** |

## SEX OF CHILDREN WHO DIED

It was anticipated that the sex of the children would be redacted. However, it was often possible to determine the sex of the child.

Of the children who died, the sex of nine of the nineteen cases could be determined. In five cases, the child was male, and in four cases the child was female.

### TABLE 7: SEX OF CHILDREN WHO HAVE DIED

| | NUMBER OF INCIDENTS |
|---|---|
| Male | 5 |
| Female | 4 |
| Unknown (due to redaction or omission) | 10 |
| **TOTAL** | **19** |

## END OF LIFE DIRECTIVES

We have used the term "End of Life Directives" to encompass "Do Not Resuscitate Orders" and the decision to terminate life-sustaining treatment (e.g., mechanical ventilation).

In fifteen of the cases, there was no mention of any advanced care directives. This is not surprising given the cases relate to children. In two cases, a decision was made to discontinue treatment and in the remaining two there was a directive not to resuscitate ("DNR").

### TABLE 8: END OF LIFE DIRECTIVES MENTIONED

| | NUMBER OF INCIDENTS |
|---|---|
| Do Not Resuscitate (DNR) | 2 |
| Discontinue Inventions Except to Provide Comfort | 2 |
| Not Mentioned | 15 |
| **TOTAL** | **19** |

## LOCATION OF DEATH

In each case, the location of the child's death was indicated on the report. In nine cases, the child died in the community. In the other ten cases, the children died in care homes, foster homes or in the hospital.

### TABLE 9: LOCATION OF CHILD'S DEATH

| | NUMBER OF INCIDENTS |
|---|---|
| Foster Home | 1 |
| Hospital | 4 |
| Care Home | 5 |
| Community | 9 |
| **TOTAL** | **19** |

## DEATH OF CHILDREN WITH A DEVELOPMENTAL DISABILITY

The existence of a "developmental disability" was inferred by the notification of a disability guardian, an indication in the narrative that a child had a communication or intellectual disability, or because the child was placed at a specialized facility with a focus on children with developmental disabilities.

In the case of one child's death, the child was known to have a developmental disability and in two cases it is suspected that the child had a developmental disability. In the remaining sixteen cases, the child does not have a developmental disability or this information is not known.

### TABLE 10 : DEVELOPMENTAL DISABILITY

| | NUMBER OF INCIDENTS |
|---|---|
| Known to be Present | 1 |
| Unsure | 2 |
| No or Not Mentioned | 16 |
| **TOTAL** | **19** |

## CATEGORY 2: SERIOUS INJURY

Category two is the serious injury of a child. The form provides four subcategories: a) caused by service agency; b) accidental; c) self-inflicted, unexplained and d) medication error. Additional codes were created for the purposes of this report and these include assault, mental health crisis, self-inflicted injury, or a medical concern that is either known or unknown.

In the 90-day period under review, there were an average 3.71 serious injuries each day. Accidental injuries account for 25.15% of the reported serious injuries. Medical problems of a known or unknown nature account for 10.74% of serious injury reports. Self-inflicted injuries (both explained and unexplained) account for 41.32% of all of the serious injuries reported. Significant mental health crises requiring hospitalization account for 10.18% of the reports of serious injury. It should be kept in mind that mental health crises requiring hospitalization were reported most frequently in *"Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client"*.

In the 90-day period under review, there were an average 3.71 serious injuries each day.

### *TABLE 11: SERIOUS INJURY BY SUB-CATEGORY*

| | NUMBER OF INCIDENTS |
|---|---|
| Caused by Service Agency (during restraint*) | 6 |
| Accidental | 84 |
| Assualt | 5 |
| Mental Health Crisis | 34 |
| Self-Inflicted, Unexplained | 15 |
| Self-Inflicted, Explained | 123 |
| Self-Inflicted General | 19 |
| Self-Inflicted Cutting | 48 |
| Self-Inflicted Punch Wall/ Object | 19 |
| Self-Inflicted Poison | 24 |
| Self-Inflicted Swallow Object | 13 |
| Medical Known | 32 |
| Medical Unknown | 4 |
| Medication Error** | 31 |
| **TOTAL** | **334** |

* Injuries that occur during restraint are more often captured in categories 7 and 8.

** Medication errors are also captured in categories 6 and 7.

## *MEDICATION ERROR REPORTED AS "CATEGORY 2: SERIOUS INJURY"*

The guidelines indicate that service providers must report medication errors resulting in an injury or illness. This 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; and wrong route of administration". Medication errors reported in the *"Serious Injury"* category feature several different kinds of errors.

There were 31 medication errors recorded in this category. In nine cases, the young person was given the wrong medication — sometimes their own, sometimes that of another individual. In thirteen situations, a scheduled dosage was missed. In five cases, an incorrect dosage was administered and twice the young person refused to take their medication.

## *TABLE 12: SERIOUS INJURY: MEDICATION ERROR*

| | NUMBER OF INCIDENTS |
|---|---|
| Wrong Medication Administered | 9 |
| Wrong Dosage Administered | 5 |
| Dosage Missed | 13 |
| Refused | 2 |
| Medication Allergic Reaction | 1 |
| Young Person Took Excessive Cold Medication | 1 |
| **TOTAL** | **31** |

## CATEGORY 3: ALLEGED, WITNESSED OR SUSPECTED ABUSE

The third type of serious occurrence is alleged, witnessed or suspected abuse of a child. The 2013 Ministry Guidelines indicate that these reports should reflect allegations arising from incidents that occur while a young person is receiving services and should not include reports of historical abuse.

There were 116 reports of alleged, witnessed, or suspected abuse. Of this number, 112 reports were allegations of abuse.

There were 116 reports of alleged, witnessed, or suspected abuse. Of this number, 112 reports were allegations of abuse.

There were 116 reports of alleged, witnessed, or suspected abuse. Of this number, 112 reports were allegations of abuse. One was a report of children witnessing an incident of domestic violence while on a home visit, and three relate to situations where community members reported the suspected abuse of a young person in care. The types of abuse identified include inappropriate discipline, neglect, corporal punishment, physical assault and sexual assault. Despite the directions in the guidelines, service providers sometimes recorded disclosures of historical abuse under this category.

In 30.5% of the cases, the allegation was about abuse by a family member, including current abuse occurring on a home visit and the disclosures of historical abuse. Allegations of abuse by a community member occurred in 8.9% of reports and the majority of these incidents involved the sexual assault of the young person.

Allegations of abuse by foster parents were reported in 22.32% of the cases and allegations of abuse by staff in 9.82% of cases. Allegations of abuse during a restraint by either a foster parent or a staff member account for 13.39% of reports. Taken together, allegations of abuse by caregivers, foster parents, and staff during restraints account for 45.3% of these reports.

It should be noted that allegations of abuse during restraint are also captured in *"Category 6: Complaint About Operational, Physical, or Safety Standards"*; *"Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client"* and *"Category 8: Restraint of Client"*.

### *TABLE 13: ALLEGED ABUSE*

| | NUMBER OF INCIDENTS |
|---|---|
| Alleged Abuse by Staff | 11 |
| Alleged Abuse by Foster Parent | 25 |
| Alleged Abuse by Foster Parent's Child | 1 |
| Alleged Abuse by Peers | 11 |
| Alleged Abuse by Family Member | 34 |
| Alleged Abuse by a Teacher | 2 |
| Alleged Abuse by Community Member | 10 |
| Alleged Abuse by a Former Adoptive Parent | 1 |
| Alleged Abuse During Restraint (Staff or Foster Parent) | 15 |
| Alleged Abuse by Unknown Person | 1 |
| Alleged Abuse by the Child | 1 |
| **TOTAL** | **112** |

## TABLE 14 : WITNESSED ABUSE

| | NUMBER OF INCIDENTS |
|---|---|
| Witnessed Abuse by Family Member | 1 |
| **TOTAL** | **1** |

## TABLE 15 : SUSPECTED ABUSE

| | NUMBER OF INCIDENTS |
|---|---|
| Suspected Abuse by Foster Parent | 2 |
| Suspected Abuse by the Child | 1 |
| **TOTAL** | **3** |

## DISPOSITION OF ALLEGATIONS OF ABUSE

A final outcome with respect to allegations of abuse was reported in 31 situations. In each of these cases the matter was investigated either by a children's aid society or the police.

The results of the investigations were as follows: 21 unsubstantiated cases, seven substantiated cases, and three inconclusive cases. In 46 cases, no information was provided on the outcome of an investigation. In seventeen cases there was a determination to take no further action, and in 22 cases a safety plan was described. 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.

## TABLE 16 : DISPOSITION OF ALLEGATION

| | NUMBER OF INCIDENTS |
|---|---|
| Substantiated | 7 |
| Unsubstantiated | 21 |
| Inconclusive | 3 |
| No Further Action | 17 |
| Safety Plan | 22 |
| No Information Provided | 46 |
| **TOTAL** | **116** |

## CATEGORY 4: MISSING

Category four is any situation where a child is missing from a residence. A missing person report must be filed with the police when a child in the care of a children's aid society or a residential program has been missing for 24 hours. The guidelines indicate that all *Serious Occurrence Reports* should describe whether the client is high risk to themselves or others as well as any attempts to locate the child, their previous history of leaving without permission, the child's state of mind before leaving, or other precipitating event.

There were a total of 944 reports of missing persons and in 63.98% of the cases, the young person returned to the program of their own volition. The police located and returned the young person in 4.13% of the reports. In just over one quarter (27.33%) of the reports, the whereabouts of the young person remained undetermined. This could be because the report was issued at the end of March (the reporting period for this review ended March 31) and the young person returned in April; the follow up reports yet to be received will disclose this information; or that the young person's whereabouts remain unknown. In less than one percent of the reports (0.95%), the young person was located but refused to return to the residence.

Often, it was not recorded whether the young person was offered medical attention or counselling when returning to the program, even in cases where the young person reports having been the victim of a physical or sexual assault while they were away. Consultations with service providers indicate that sometimes this information may be recorded in incident reports (which are maintained at the residence but not filed with MCYS).

It should be noted that the reports of missing persons may in some cases be the same young person repeatedly running. The Advocate's Office will include more details regarding young people who were missing from children's residences in the final report.

### *TABLE 17: MISSING YOUNG PEOPLE*

| OUTCOME | NUMBER OF INCIDENTS |
|---|---|
| Returned to the Program | 604 |
| Location Unknown at Sign Off | 258 |
| Bed Closed | 28 |
| In Detention | 6 |
| Police Returned | 39 |
| Refused to Return | 9 |
| **TOTAL** | **944** |

## CATEGORY 5: DISASTER ON PREMISES

A disaster on the premises is the fifth category of occurrence. These were situations that interfere with the daily routines of the residence such as fire, gas leak or another significant disruption.

There were sixteen reports of disaster that occurred on residence premises. Disasters reported include fire, break-in or theft, bomb threat, activation of emergency alarm or situations that render the building unsafe. There were seven disasters involving fires. There were two bomb threats and one break-in. In three reports the building was deemed unsafe as a result of water damage in one case, lack of access to water in another, and mould contamination in the third. In one situation the "panic" alarm was activated by mistake. In two cases, service disruptions were reported as disasters. One incident involved the cancellation of a bus taking children to Intensive Behavioural Intervention treatment due to inclement weather and the other was a disruption to internet service, impacting on the phone lines.

### *TABLE 18 : DISASTER ON THE PREMISES (BY TYPE)*

| | NUMBER OF INCIDENTS |
|---|---|
| Fire | 7 |
| Bomb Threat | 2 |
| Break-in/Theft | 1 |
| Building Unsafe | 3 |
| Alarm Activated | 1 |
| Service Disruption | 2 |
| **TOTAL** | **16** |

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

The sixth category of occurrence includes a complaint about the operational, physical or safety standards of the residential program. The guidelines indicate that programs should report: "adverse water quality; reports of excess lead; improper storage of hazardous/ dangerous substances; medication error (not resulting in an injury or illness) and missing or stolen files".

Medication errors comprised the largest number of operational errors followed by concerns about water quality. In addition, there was one complaint by a neighbour, one complaint of missing files and one complaint that the physical plant was unsafe. Safety concerns included allegations of abuse of young people by staff, foster parents, or in the context of restraint. There were three situations where individuals were criminally charged: charges were brought against one staff, one peer, and one foster parent. In addition, there was one situation where the fire alarm was activated, one where the police attended the residence, and one where the young person's safety was at risk due to a threat posted on Facebook.

Safety concerns included allegations of abuse of young people by staff, foster parents, or in the context of restraint.

As mentioned earlier, medication errors not resulting in injury or illness should be recorded in this category. Missed dosages account for 72.73% of medication errors reported in this category. In two cases the wrong medication was administered and in four cases the wrong dosage was given to the young person.

### *TABLE 19: COMPLAINTS ABOUT THE OPERATIONAL, PHYSICAL OR SAFETY STANDARDS OF THE RESIDENCE*

| | NUMBER OF INCIDENTS |
|---|---|
| Operational Standards | |
| Medication Error | 22 |
| Service Breach, Missing Files | 1 |
| Complaint by a Neighbour | 1 |
| Water Advisory | 4 |
| Safety Concern Regarding Physical Plant | 1 |
| Safety Standards | |
| Alarm Activated | 1 |
| Allegation About Staff | 4 |
| Allegation About Foster Parent | 4 |
| Allegation in Context of Restraint | 2 |
| Staff Charged | 1 |
| Peer Charged | 1 |
| Young Person Charged | 1 |
| Foster Parent Charged | 1 |
| Police Attend | 1 |
| Young Person's Safety at Risk | 1 |
| **TOTAL** | **46** |

### *TABLE 20 : MEDICATION ERROR REPORTED IN CATEGORY 6*

| | NUMBER OF INCIDENTS |
|---|---|
| Wrong Medication Administered | 2 |
| Wrong Dosage Administered | 4 |
| Dosage Missed | 16 |
| **TOTAL** | **22** |

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

Category seven involves situations of a complaint made by or about a client or other serious occurrence involving a client. The guidelines include situations such as a child in the residence being assaulted by a non-caregiver, assault by another child in the residence, police involvement with a child or youth, hospitalization where the child or youth is admitted as an in-patient, inappropriate disciplinary techniques, and complaints arising from sexual contact between young people.

The complaint by a child or youth category encompasses a range of concerns brought forward by young people and account for 108 of the reports. Of the complaints made by a young person, 75% relate to an assault. Complaints about the service account for 17 of the situations and there are three complaints about theft.

Complaints made about a child or youth account for 380 of the reports categorized in this section. Police matters about a young person comprise 56.05% of the incidents in this section. There were 160 reports where the young person assaulted another young person. In addition, seven complaints were received from neighbours. Complaints by neighbours are also reported in *"Category 6: Complaint About Operational, Physical, or Safety Standards"*.

The majority of other serious concerns were related to medical crises that resulted in hospitalization. Of these, 113 related to physical illnesses and 206 were mental health crises. In 92 situations of mental health crises requiring hospitalization, the police brought the young person to the hospital. Drug or alcohol crises account for seven incidents. There were 23 motor vehicle accidents. In 80 reports, there were serious concerns or allegations related to historical abuse by family members or community members, or that occurred in facilities. There were seven situations of uninvited guests at the residence and eight situations where there was significant conflict with the child or youth's parents.

There was a service disruption or service breach in 21 cases. Again, these types of incidents are also recorded or may be recorded in other categories of the form. In total, there are 1,010 complaints made by or about a client or other serious occurrences reported during this time period.

## *TABLE 21: COMPLAINT MADE BY OR ABOUT A CLIENT, OR OTHER SERIOUS OCCURRENCE INVOLVING A CLIENT*

| | NUMBER OF INCIDENTS |
|---|---|
| Complaint Made by a Client | |
| Assault by a Staff | 13 |
| Assault by Foster Parent | 7 |
| Assault by Peer | 37 |
| Assault in Community | 24 |
| Concern with Family Interaction | 7 |
| Complaint About Service | 17 |
| Theft | 3 |
| **SUBTOTAL** | **108** |
| Complaint About a Client | |
| Assault of Another Client | 160 |
| Police Matter About Client | 213 |
| Neighbour Complaint | 7 |
| **SUBTOTAL** | **380** |
| Other Serious Concern | |
| Medical Crisis | |
| Medical Crisis: Physical | 113 |
| Medical Crisis: Mental Health | 206 |
| Drug or Alcohol Crisis | 7 |
| Suicide Risk (not hospital) | 1 |
| Motor Vehicle Accident | 23 |
| Uninvited Guest | 7 |
| Conflict with Client Parent | 8 |
| Medication Error | 22 |
| Service Disruption | 16 |
| Service Breach | 5 |
| Serious Concern or Allegation | 80 |
| Other Serious Occurrence | 34 |
| **SUBTOTAL** | **522** |
| **TOTAL** | **1,010** |

Despite instructions that medication errors should be recorded in either *"Category 2: Serious Injury"* or *"Category 6: Complaint About Operational, Physical, Safety Standards"*, a total of 22 incidents were recorded in this category. In one case, a noxious substance was accidentally administered. In two cases, the young person refused their medication. In four cases, situations required medical care due to allergic reaction, overdose or errors with the administration of medications. The wrong medication was administered three times, and the wrong dosage was given five times. A scheduled medication dose was missed on seven occasions and in one of these occasions the missing medication was insulin. It should be noted that typically the names of the medications are redacted in these reports so this may not be the only occurrence where insulin was not provided. Medication errors reported in this category are further broken down in Table 22.

### *TABLE 22: MEDICATION ERROR REPORTED IN CATEGORY 7*

| | NUMBER OF INCIDENTS |
|---|---|
| Wrong Medication Administered | 3 |
| Wrong Dosage Administered | 5 |
| Dosage Missed | 7 |
| Refused | 2 |
| Medication Allergic Reaction | 1 |
| Medication Review Needing Hospitalization | 2 |
| Young Person Consumed OTC Medication | 1 |
| Administered Noxious Substance | 1 |
| **TOTAL** | **22** |

## CATEGORY 8: RESTRAINT OF CLIENT

The final category of occurrence is restraint of client. The largest numbers of *Serious Occurrence Reports* are filed about the physical restraint of a child. There were a total of 2,354 separate incidents where the use of a physical restraint on a child was reported.

Physical restraints account for 48.65% of all *Serious Occurrence Reports* submitted in this time period. It is often difficult to determine which of the approved physical restraint techniques were used, whether or not de-escalation techniques had been attempted prior to using a restraint, and if a de-briefing occurred after the restraint. The young person's account of events was rarely provided in the report, despite a section on the form where it could be included.

The largest numbers of *Serious Occurrence Reports* are filed about the physical restraint of a child. There were a total of 2,354 separate incidents where the use of a physical restraint on a child was reported.

Police were often called in the context of a restraint and there were many situations where there were multiple restraints in the course of one incident. There were also a number of instances where restraints were aborted because it was unsafe for the staff and young people involved.

The use of physical restraints on individuals with a developmental disability was examined. This was identified by the notification of a disability guardian being indicated on the form, the narrative indication that a child had a communication or intellectual disability, or because the child was placed at a facility with a specialization in working with children with developmental disabilities. Young people were known to have or it was suspected that they had a developmental disability in 737 of the reports on the use of restraints which represents 31.31% of reported restraints. It is noted that restraints on young people with developmental disabilities had several features that were different than in other situations: more staff involvement, frequent use of medication prescribed to be taken when needed (generally referred to as a "PRN")[12] and a duration that is frequently less than 10 minutes in total time. We noted several situations where the police were called to help restrain the child and sometimes the child was mechanically restrained and detained. There will be more discussion about the unique needs and necessary safeguards for persons with developmental disabilities in the final report.

### *TABLE 23 : RESTRAINT*

| | NUMBER OF INCIDENTS |
|---|---|
| Restraint of a Child | 2,354 |

### *TABLE 24 : RESTRAINT OF CHILD WITH A DEVELOPMENTAL DISABILITY*

| | NUMBER OF INCIDENTS |
|---|---|
| Known to Be Present | 568 |
| Suspect | 169 |
| No or Not Known | 1,617 |

[12] PRN, or Pro Re Nata, it is a Latin phrase meaning "in the circumstances" or "as the circumstances arises".

# E: PRELIMINARY OBSERVATIONS FROM THE CURRENT REVIEW

## QUALITY OF COMPLETED REPORTS

Wide variability was found in terms of the quality of the Serious Occurrence forms submitted by service providers. Some problems with the written reports related to confusion caused by poor grammar and sentence structure. Some reports were handwritten and difficult to decipher. Many reports were missing key information such as date and time, the name of the person writing the report, the names of individuals notified, and the current status or condition of the situation.

Many reports were missing key information such as date and time, the name of the person writing the report, the names of individuals notified, and the current status or condition of the situation.

Section C of a *Serious Occurrence Report* directs service providers to provide a summary of the occurrence and provides specific instruction about the content that should be contained in the report: "[w]hat, where and when it happened, including action undertaken by the service provider".

In reading the reports, it was often difficult to determine what exactly happened, what was done in response to the incident and what follow up or debriefing occurred after the serious incident had ended. Nonetheless, by coding each occurrence, it was possible to generate a set of descriptive codes for each incident. For example, for each serious injury we could determine the type of injury or if it was accidental, self-inflicted or as a result of the actions of another. Similarly for complaints we were able to generate a list of descriptors for each incident and these findings are reported in the tables found in this report.

The poor quality of the reports is largely due to the use of vague and "stock" phrases such as "aggressive towards the environment", "in staff's personal space", "imminent threat", or "became visibly aggressive" rather than a specific description of what has actually occurred. Descriptive wording such as the child hit, kicked or spit at, provide more clarity about the level of risk to staff or others than stock phrases such as "aggressed towards staff". In cases where a report is filed due to the use of a physical restraint on a young person, there is a particular need for clarity because of the legal threshold that must be met before such a restraint can be employed. This threshold is described in the regulations to the *Child and Family Services Act* as a "clear and imminent risk" that the young person will physically injure or further physically injure him/herself or others.[13] Phrases such as "aggressive towards the environment" and "imminent threat" do not convey enough information to demonstrate to the reader that the legal criteria that permits the use of this intrusive measure was met.

Another problem relates to the completeness of the reports submitted about the death of children. As noted earlier, one particular agency routinely used the phrase, "Patient died due to illness. Death expected". This stock phrase was noted in four cases and there was no further information provided in Section C of the reports. As noted earlier, Section C of the *Serious Occurrence Report* form instructs service providers to summarize the incident and describe "[w]hat, where, and when it happened" and "actions taken by service providers".

For comparison purposes, all *Serious Occurrence Reports* related to the deaths of children during an 18-month period from September 2014 to December 2015 were reviewed. During this time frame the same agency referred to above reported six cases, where a child had died. Again, the identical wording was used in each case: "Patient died due to illness. Death expected". In four of these cases the guardian was described as "parent". In two cases guardianship could not be determined due to redactions. In each of the

13 RRO 1990, Reg 70, s 109.1 (2)

six reports, it was indicated on the form that the service provider did not expect to provide any further reports to MCYS on the occurrence. These were then compared with cases where a child deemed to have complex medical needs had died in a hospital. In each case, where the death occurred in hospital, detailed information about the circumstances leading up to the death and actions taken by service providers was noted in section "C". (These cases were reported to MCYS due to the involvement of a children's aid society in the case, not because hospitals are required to submit *Serious Occurrence Reports*).

One should not assume that simply because a child is in a residence that specializes in palliative care, that there is no need to provide information about the circumstances of that child's death. In 1990, the Auditor General of Ontario obtained *Serious Occurrence Reports* related to the deaths of children at government-funded homes for people with "developmental handicaps" and cross-referenced these reports with the residential service provider's medical committee minutes. It was noted by the Auditor General that many of the deaths had similar causes and that problems with feeding and nutrition appeared to be contributing factors in many of the deaths.[14] These findings led to a ministry investigation and the subsequent involvement of the Chief Coroner of Ontario who established a medical review team to examine the deaths of 47 children from 1986 – 1990 at some of these residences. From this review an inquest into the deaths of 15 young people at one particular group home and another inquest into the deaths of four young people at another home were called.

Any person reviewing a Serious Occurrence Report of a child's death should have a clear understanding about what happened to that child.

The Advocate's Office obtained the Verdict of the Coroner's Jury for 16 of these deaths.

In four cases the means of death recorded on the jury verdict in the April 1992 inquest is as follows:

> *An inappropriately commenced palliative treatment process involving the administration of morphine sulphate for a potentially treatable illness that was deemed to be terminal without benefit of confirming diagnostic testing.*

In four additional cases the means of death recorded by the jury verdict in the April 1992 inquest states:

> *An inappropriately commenced palliative treatment process involving the administration of morphine sulphate for a potentially treatable illness that was deemed to be terminal without benefit of confirming diagnostic testing. Later investigation revealed the presence of RSV in the home in the month of September.*

The purpose of these examples is to show that allowing an agency to simply report the circumstances of a child's death as "expected", deprives MCYS of an opportunity to identify situations in which the safety and well-being of children may be at issue. Any person reviewing a Serious Occurrence Report of a child's death should have a clear understanding about what happened to that child. For example, was the child awake or asleep when the death occurred? Was anyone with the child or did the child die alone? What was the relationship of this person to the child? If the child was palliative, was there a Palliative Care Plan, what was it and was it followed? The reports in question only tell us that a child died on a specific date. This practice should not be allowed to continue.

14 Office of the Auditor General of Ontario, 1990 p 96

## DESIGN AND FORMAT OF REPORTS

**(a) *Lack of Standardization***

There are various different versions of the *Serious Occurrence Report* in use, with some agencies creating their own, and not all of them capturing the same information. On the other hand, some of the idiosyncratic forms created by individual agencies contain features that add clarity:

- Some forms have a space to include Wardship data and this is particularly useful for ensuring that the guardian is notified.
- Some agencies attach a "High Risk Client" form that can be helpful to understanding the risks faced by a young person who is missing. This form forces the author of the report to identify specific safety concerns such as the existence of a developmental disability, or by indicating that a child is at risk of harm to him or herself or by others or if there is a risk related to a medical condition.

**(b) *Same Form for Two Ministries Causes Confusion***

The Ministry of Community and Social Services use the same categories and forms (e.g. *Serious Occurrence Reports*) to monitor incidents related to someone over eighteen years of age who is placed in a residential service funded by the Ministry of Community and Social Services. The names of both ministries appear on the forms, and there appears to be a number of different versions of the form in use across the province. It is not the intention of this report to address any problems in the adult residential services sector. However, there are unintended consequences that result from the use of the same form for both children and adults that should be addressed.

*"Category 8"* of a *Serious Occurrence Report* relates to the use of physical restraints and is split into two with a separate set of subcategories for restraint of an adult client with a developmental disability and for use with children/youth. We believe the intent is to ensure enhanced safeguarding for adults with developmental disabilities regarding restraints, given the known vulnerability of this client population. However in practice, this seems to be confusing to service providers and sometimes children are coded in the section intended for adults. This may be because the options available for adults signal that the use of the physical restraint was justified, which may be more appealing to service providers. For example, the options available for children include: "no injury", "injury" and "allegation of abuse". Whereas for adults, the options include: "physical restraint-crisis situation", "physical restraint,-challenging behaviour and resulted in injury"; "physical restraint- challenging behaviour resulted in an allegation of abuse" and "mechanical restraint".

This section might act more effectively as a safeguard if there was simply a box to check off that indicates that the adult or young person has increased vulnerability such as a developmental disability. The sub-categories could include: "without injury", "with injury", "with allegation" of abuse, "with mechanical restraint". The justification for the use of the restraint could and should be fully explained in Section C, which already instructs service providers to detail the circumstances of the serious occurrence.

> …there are unintended consequences that result from the use of the same form for both children and adults that should be addressed.

**(c) *Reporting the Same Types of Events in Different Categories Obscures the Extent of the Problem***

Understanding the true extent of medication errors is made difficult by Ministry directives to split reporting into two categories and is further muddled when medication errors are also mistakenly recorded in a third category. If, for example, the annual roll-up reports of *"Category 2: Serious Injury"* was relied on to identify the significant medication errors, those reported in categories 6 and 7 would be missed. As a case in point, this review found that 41% of medication errors were reported as a Serious Injury, with the remaining medication errors spread equally over the other two categories. Considering only wrong medication administered and wrong dosage administered (which the Advocate's Office believes to be a serious injury or has the potential to be so) fourteen were found reported as *"Category 2: Serious Injury"* and fourteen reported as either *"Category 6: Complaint about*

*Operation, Physical, or Safety Standards"* or as *"Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client"* for a total of 75 medication errors.

It is not easy to discern the difference between errors reported (as per the guidelines) as a *"Category 2: Serious Injury"* (i.e. Medication errors that resulted in an injury/illness) and those required to be reported as *"Category 6: Complaint About Operational, Physical, or Safety Standards"* (i.e. Medication errors not resulting in an injury or illness). Determining whether the misadministration of a medication resulted in injury would seem to be a medical judgment beyond the scope of the training of a frontline residential worker.

Another example of confused reporting across multiple categories is self-inflicted injury. For example in *"Category 2: Serious Injury"*, there were 138 reported cases of self-harm. In addition, in *"Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client"* there were 73 reported cases of self-harm. Together there are a total of 211 confirmed incidents of self-harm which would be missed if only *"Category 2: Serious Injury"* was relied on to understand the extent of self-inflicted injury.

**(d) *Different requirements for Abuse Reporting Depending on Age***

A note on the form under *"Category 3: Alleged, Witnessed, and Suspected Abuse"* states:

> *Note: For MCSS Developmental Services and Supports, any alleged, witnessed or suspected abuse that may constitute a criminal offence must be immediately reported to the police and requires an Enhanced Serious Occurrence Report.*

It is important to highlight that alleged, witnessed or suspected abuse may constitute a criminal offence and this is important to highlight in order to protect vulnerable adults. However, by not mentioning the duty to report child abuse here, there is a risk that service providers may become confused about what gets reported to who and when. The law requires that allegations of abuse against children to be reported to a Children's Aid Society and we suggest that this reminder also be included in this section.

Taken together, these problems impair the ability of *Serious Occurrence Reports* to function effectively as a tool to safeguard children in residential care.

Taken together, these problems impair the ability of *Serious Occurrence Reports* to function effectively as a tool to safeguard children in residential care. As a first step, MCYS should develop its own comprehensive *Serious Occurrence Report* form in order to resolve the structural confusion in the form that currently exists. This new form should be placed on the Ontario Central Forms Repository with full functionality to fill, print and submit directly from the website. Service providers should be required to fully complete all sections of the new form so that, in every single case, the reader is able to determine what exactly happened, what was done in response to the incident, what follow up or debriefing occurred after the incident ended, and what the young person said about the situation.

## CENTRALIZED DATABASE

The juries at two separate inquests into the death of a child in residential care have recommended that the government create a quality review process by establishing a centralized database to monitor serious occurrences. At the Inquest into the death of William Edgar, it was recommended the contents of the database be available to external and internal researchers.[15] Similarly, the jury at the Inquest into the death of Stephanie Jobin recommended the creation of a database that would be accessible by all Ministry Regional Offices and local children's aid societies.[16]

This interim report and our upcoming follow-up final report represent one example of how information can be centrally collected, analyzed, and publicly reported upon in a way that protects the privacy of individuals…

As part of the review of *Serious Occurrence Reports*, the Advocate's Office was able to create a database to assist in our analysis. Despite the problems with the completed *Serious Occurrence Reports* in terms of quality and format, the reports contained important information about certain aspects of residential care, especially with respect to the use of intrusive measures such as physical restraints and requests by service providers for the involvement of police. Although this is a preliminary report and more detailed findings will be available in the coming weeks, we have been able to determine that approximately half of the *Serious Occurrence Reports* filed with MCYS relate to the use of physical restraints (2,354), and that there were 944 missing persons reports and 75 medication errors over the span of the first three months of 2014.

In meetings with MCYS, we were advised of the existence of a database for the *Serious Occurrence Reports*. However, we are concerned that the existing MCYS database does not provide an accessible means by which MCYS is able to identify trends, patterns or issues that may be related to the care of children. For example, earlier this year, the Advocate's Office was informed by a member of the Legislative Assembly about a question posed to MCYS by way of a request under the *Freedom of Information* and *Protection of Privacy Act*. Information was sought on the number of reported injuries or hospitalizations of children in care and the number of hospitalizations as a result of self harm. The official response from MCYS was that "the statistic you have requested is not tracked by the ministry".[17] Based on our own review of the three-month period, we were able to determine the following statistics in response to the question:

- 335 cases of serious injury
- 88 injuries related to the use of a physical restraint
- 94 cases in which injuries related to self harm were reported under *"Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client"*
- 366 hospitalizations
- 85 hospitalizations as a result of self-harm.

This interim report and our upcoming follow-up final report represent one example of how information can be centrally collected, analyzed, and publicly reported upon in a way that protects the privacy of individuals, yet allows for discussion of the serious issues being reported in the residential care system. This review demonstrates that it is possible to develop a searchable database that produces useful and relevant reports that can be used to safeguard children.

[15] Office of the Chief Coroner of Ontario, Inquest into the Death of William Edgar Verdict of the Jury (Peterborough: 2001) recommendation 13

[16] Office of the Chief Coroner of Ontario, Inquest into the Death of Stephanie Jobin, Verdict of the Jury (2002) Recommendation 28

[17] Personal Correspondence between Ministry of Community and Social Services/Ministry of Children and Youth Services Freedom of Information and Protection of Privacy Unit and NDP Caucus Services dated September 11, 2015.

# E: SERIOUS SITUATIONS TO BE REPORTED MORE FULLY IN NEXT REPORT

Incidents of self-harm, the use of restraints, and what happens when children "go missing" will be discussed in greater detail in the final report. These issues have generated significant concern at the Advocate's Office for a number of years. The history and reason for these concerns as well as some of the different perspectives of those who have involvement in these situations are included in this report in order to generate a wider discussion about safety, risk, and best practice.

## SELF-HARM

As noted earlier, there were a total of 211 confirmed incidents of self-harm. The Advocate's Office suspects that this number is under reported because in some reports the description of the events suggests the child is self-harming without explicitly stating so. This is implied by use of phrases like "suicidal behaviours" without any further description. Self-harming behaviour is frequently noted in the context of *"Category 8: Restraint of Client"* and in *"Category 7: Complaint Made by or About a Client, or Other Serious Occurrence Involving a Client"*.

In addition to self-harming behaviour, there are also reports of "SIBS", which refers to repetitive self-injurious behaviours, most frequently reported in children with intellectual and developmental disabilities. These can include head banging, and pulling hair or picking skin until it bleeds.

## MISSING PERSONS

Our review found 944 reports of missing young people and, in just shy of 64% of the cases, the young people returned to the residence of their own volition. In discussions, service providers spoke a fair bit about young people who are considered as missing. In general, there was concern about different risk profiles of young people who go missing and the challenges they face reporting these missing young people to the police.

Clearly, some young people were quite vulnerable when they were missing, such as those with a history of exploitation or those with a developmental disability, while other young people were away from the program without permission but were expected to return and so, were viewed as less vulnerable. In other cases, some young people frequently ran away and then returned to the residence.

> ...there is a need for a broadly based discussion about children and youth who go missing from residential care and the best way in which the service system should respond.

In service provider consultations, concerns were identified about the police response to missing young people. These concerns included reports about the apparent unwillingness of some police services to accept missing person reports related to young people living in group care and jurisdictional restrictions about where a service provider could file a missing person's report (e.g., agencies told by one police service a report can only be filed in the jurisdiction where the young person was **last seen** and later told by another police service a missing persons report can only be filed with the police service where the young person regularly **resides**). Similar barriers to filing missing persons reports have been documented in other Canadian jurisdictions, most notably in a report commissioned as part of an official inquiry into missing and murdered women in British Columbia which summarized self-reported information from twenty police services across the country about missing person practices and procedures during the period of 1997 – 2012.[18]

[18] Elizabeth Welch, Practices and Procedures in the Investigation of Missing Persons Across Canada: 1997 to Present, A Report Prepared for the Missing Women Commission of Inquiry (British Columbia: 2012)

In turn, the Advocate's Office has also been made aware of the concerns of various police services with respect to missing persons reports and young people in care. The most commonly identified issue is that service providers wish to file missing person's reports on young people who are not really missing but simply absent from the premises without permission. Police officials question whether there is a need for police involvement in these types of situations. Another issue raised by police is the perception of some hospital staff that, due to privacy concerns, they are not able to share information with police, even when it could help locate a missing young person.

Young people interviewed by the Advocate's Office — either as part of general focus groups or due to reviews by the Advocate's Office of specific residential facilities — have echoed concerns similar to those raised by police. In addition, some young people identified that once they have returned to the residence, they are unlikely to be asked by workers or other service providers why they left, what happened to them while they were away, and what might prevent them from running again.

Our final report will include a deeper analysis of the information contained in *Serious Occurrence Reports* about missing persons. In the meantime, we believe there is a need for a broadly based discussion about children and youth who go missing from residential care and the best way in which the service system should respond. The policies and practices related to police services across the province in relation to this group of young people should also be clarified and standardized.

## PHYSICAL RESTRAINT

The use of physical restraints on young people in residential care is governed under Regulation 70 of the *Child and Family Services Act*. These regulations set out when a restraint can be used ("clear and imminent risk of physical injury to the young person or others"), what techniques of restraint are to be applied (only those approved by MCYS), and when the restraint must be terminated (once the "clear and imminent risk" has ended). The regulations stipulate that a physical restraint cannot be used as punishment, that a young person's condition must be continually monitored during the restraint, and that a debriefing must occur with the young person within 48 hours of the restraint being carried out. These legal rules have not always been in place, and came into effect only after two separate inquests into the deaths of young people who died as the result of physical restraints. The deaths occurred in June 1998 and April 1999 during or immediately after the administration of a restraint.[19]

The use and misuse of physical restraints on young people in residential care is of great concern to the Advocate's Office. In 1998, the Office of Child and Family Service Advocacy, the forerunner to the current Office of the Provincial Advocate for Children and Youth, released a report, *Voices from Within: Youth in Care in Ontario Speak Out*.[20] The data from that report was based on focus groups with 315 young people receiving services from the child welfare, children's mental health, and youth justice sectors in Ontario. Young people participating in these sessions had more to say about the use of physical restraints than any other issue that came up during the discussions. Concerns about restraints ranged from complaints about the excessive use of force during a restraint, to concerns that restraints are a first response rather than a last resort. There also seemed to be an apparent lack of rules governing the use of restraints, minimal use of de-escalation techniques before the restraint and lack of de-briefing afterwards. One of the recommendations from that report was that, "[a]ny form of physical restraint needs to be viewed as a serious occurrence with all the implications this entails".

In 2001, the Ministry of Community and Social Services (then responsible for children's services) issued a policy directive to all service providers that: (1) defined physical restraints ("the physical control of a child by one or more persons to safely restrict the movement of a child using one of a variety of holding techniques, with the least amount of force necessary to inhibit the ability of the child to move freely"); (2) required the person administering physical restraints to be trained

[19] Ministry of Community and Social Services, Memorandum to CFSA Service Providers re Physical Restraints Policy in Children's Services (June 18, 2001)

[20] Kim Snow & Judy Finlay, Voices From Within: Youth in Care in Ontario Speak Out (Toronto: Queen's Printer for Ontario, 1998) provincialadvocate.on.ca/documents/en/VOICES%20FROM%20WITHIN.pdf

in behaviour management techniques; (3) restricted the use of physical restraints to situations where "the safety of the child or other persons is immediately at risk"; and (4) limited use of physical restraint to be used only after less intrusive behavioural interventions had been considered and, where appropriate, attempted first. Significantly, this policy directive was issued the day before the inquest into the death of one of two children who died in Ministry licensed children's residences.

In the wake of that inquest, the Ontario government issued a six point action plan including regulatory changes to the *Child and Family Services Act* restricting the use of physical restraints and mandatory reporting on the use of any physical restraint by a service provider to the local Ministry Regional Office for review and follow up.

## The use and misuse of physical restraints on young people in residential care is of great concern to the Advocate's Office.

It is clear that residential staff face a considerable amount of aggression from some young people in their care. Our review details situations where young people expressed significant upset and this manifested in acts of self-harm, damage to property, or aggression towards others. Many reports detailed staff skillfully defusing situations where young people hit, kicked and spat at them or threw objects at them. The reports detailed significant mental health crises where young people posed immediate risk to themselves or to others. However, there were also many reports which did not provide enough information to know what happened before the aggression, what was done to de-escalate the situation, and what interventions were used or for how long.

At times it is unclear what the threat was that the staff perceived, or if de-escalation was attempted. It also seemed in some reports that non-compliance by a young person to a direction by staff is the precipitator of the restraint. This is very concerning because it is directly contrary to the regulations governing the use of physical restraints. In addition, the Ministry of Community and Social Services/ Ministry of Children and Youth Services, *Serious and Enhanced Serious Occurrence Reporting Guidelines* (2013), require service providers to "describe the type of restraint used, use of less intrusive interventions before the restraint, client and staff debriefing, legal status of the client and the duration of the restraint…" Similarly, the instructions in Section C of the *Serious Occurrence Report* direct the service provider to include information about the "current status/condition, person's views/allegations, and service agency action".

Most interventions were quite brief, although some lasted hours, involved police, and at times became so unsafe that they were aborted. There were also situations documented in the reports that we reviewed when multiple restraints were used in a very short period of time.

Almost a third of restraints were used with young people we believe to have a developmental disability. There was frequent use of PRN medication (those prescribed "as needed") in those with a developmental disability while other physical interventions were often very brief lasting only a moment or two.

The final report will include a detailed analysis of the situations involving physical restraint. The concerns about the quality and thoroughness of the reports noted earlier also apply to the use of physical restraints. In reviewing the reports, it is not always clear what led up to the restraint, what type of restraint was used, how long it was applied or how many individuals were involved in the restraint. Some variation in the final numbers of occurrences related to physical restraints is anticipated once all *Enhanced Serious Occurrence Reports* and *Follow-up Reports* are examined.

# F: CONCLUSION

The very reason for the existence of a *Serious Occurrence Report* or an *Enhanced Serious Occurrence Report* is to ensure that there is immediate ministry oversight when certain things happen to children in care. Events like the use of a physical restraint on a young person, calls for police assistance when a young person is in crisis or goes missing, and the death of a young person in care, are obviously of significant concern to the government — or should be. We note that the perspective of the young person is mostly left blank in the reports. Discussion on the absence of youth voice in the *Serious Occurrence Reports* will comprise a significant component of the final report.

The Ministry has an important role in safeguarding young people in residential care. The Ministry's oversight responsibilities serve to ensure that individual residential programs for young people are held to the highest standards. Serious Occurrence Reports act as an early "warning system" to alert the government to trends, patterns and concerns.

The next steps to improve safeguarding of young people in residential care is to make full use of the information available to the Ministry in the *Serious Occurrence Reports* as these can provide valuable information about the care provided. It is crucial for MCYS to monitor *Serious Occurrence Reports* in real time so that any concerning issues involving an individual child or youth can be immediately addressed. It is equally important for MCYS to review and analyze the data contained in *Serious Occurrence Reports* over time to understand more about what children and youth are actually experiencing in residential care. The information contained in *Serious Occurrence Reports* — which include the use of intrusive measures such as physical restraint and requests for police involvement should be made accessible for analysis. This should be undertaken in a way that protects the privacy of the individuals involved. The information gathered in *Serious Occurrence Reports* provides the Ministry with potentially useful information for safeguarding children and improving services. Information of this type can inform the development of best practices methods and prompt research directed towards improving care.

The next steps to improve safeguarding of young people in residential care is to make full use of the information available to the Ministry in the *Serious Occurrence Reports*

# G: RECOMMENDATIONS

1. The *Serious Occurrence Report* form should be reconfigured to reduce multiple reporting categories, highlight risk, and identify Wardship status.
2. MCYS should direct that all sections of the *Serious Occurrence Report* form be fully completed. (A person who has had no involvement in the incident that is the subject of the serious occurrence report should be able to read the report and understand what happened).
3. MCYS should require that the young person involved in a Serious Occurrence be provided with the opportunity to record their version of events in a timely manner.
4. MCYS should impose standards for reporting on the use of physical restraints that, at minimum, include: a descriptor of the imminent threat or occurrence, details of attempts to de-escalate or prevent the occurrence if applicable, the name of the technique used as an intrusive measure, the initials of all staff involved, the length of the restraint and the time of the incident, a summary of the debriefing procedure, and a record of any injuries that result from the intervention.
5. MCYS should require immediate staff training in medication administration. This includes diligent record keeping, clarity of instruction regarding PRN dosing, and procedures to prevent medication errors.
6. MCYS, jointly with the Office of the Provincial Advocate for Children and Youth, should convene roundtable discussions about young people who go missing.
7. MCYS, jointly with the Office of the Provincial Advocate for Children and Youth, should immediately convene roundtable discussions about the restraint of young people in residential care.
8. MCYS should create an electronic database, accessible to service providers, the public, children's aid societies, and the Office of the Provincial Advocate for Children and Youth that centralizes serious occurrence reporting and allows for robust reporting.
9. *Serious Occurrence Reports* relating to the death of children in care should require fulsome descriptions including the name of the disability, the cause of death, the circumstances surrounding the death, those present at the death and names of the guardians and others notified about the child's death.

# SERIOUS OCCURRENCES REPORT

The Office of the Provincial Advocate for Children and Youth would like to acknowledge Dr. Kim Snow, Associate Professor, School of Child and Youth Care, at Ryerson University in Toronto, for her work as co-author of this report.

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