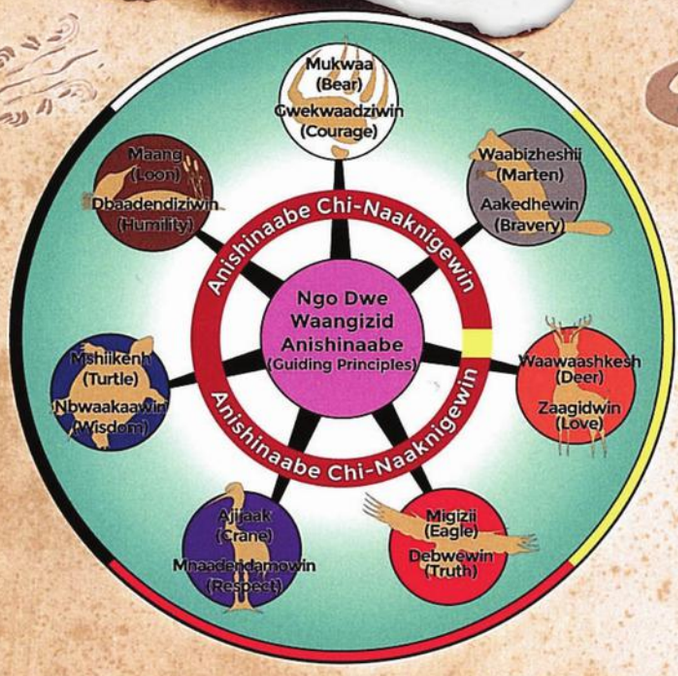
ANISHINABEK NATION

Report and Recommendations

Submission to the
Office of the Chief Coroner
regarding Child and Youth
Death Review Transformation

Prepared by:
Legal Department Anishinabek Nation
Fall, 2024



NGO DWE WAANGIZID ANISHINAABE

One Anishinaabe Family

Debenjiged gii'saan anishinaaben akiing giibi dgwon gaadeni mnidoo waadiziwin.
(Creator placed the Anishinabe on the earth along with the gift of spirituality.)

Shkode, nibi, aki, noodin, giibi dgosdoonan wii naagdowendmang maanpii shkagmigaang.
(Here on mother earth, there were gifts given to the Anishinabe to look after, fire, water, earth and wind

Debenjiged gii miinaan gechtwaa wendaagog Anishinaaben waa naagdoonjin ninda niizhwaaswi kino maadwinan:
(The Creator also gave the Anishinabe seven sacred gifts to guide them. They are:)

Zaagidwin, Debwewin, Mnaadendmowin, Nbwaakaawin, Dbaadendiziwin, Gwekwaadziwin miinwa Aakedhewin.
(Love, Truth, Respect, Wisdom, Humility, Honesty and Bravery.)

Debenjiged kiimiingona dedbinwe wi naagdowendiwin.
(Creator gave us sovereignty to govern ourselves.)

Ka mnaadendanaa gaabi zhiwebag miinwaa nango megwaa ezhwebag, miinwa geyaabi waa ni zhiwebag.
(We respect and honour the past, present and future.)

Preamble to the Anishinaabe Chi-Naaknigewin (Anishinabek Nation Constitution)
Adopted by the Anishinabek Grand Council - June 6, 2012

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Message From Anishinabek Nation Grand Council Chief Linda Debassige

The Office of the Chief Coroner's Child and Youth Death Review (CYDR) Process was established to review and investigate deaths of children and youth where service systems are involved. Historically, this Unit was developed with processes implemented without our consultation, engagement or participation. Decisions were made in isolation and on our behalf and on the behalf of the Spirits of our children who passed on to the Spirit World. The community and family were excluded. The CYDR process has historically been drenched in colonial principles and standards which failed to include First Nations culture, needs and perspectives. Today, we are proud and honoured to be a part of the Office of the Chief Coroner's efforts towards reconciliation and to collaboratively begin the transformation of an archaic and colonial system into a new system that recognizes that the inclusion, participation, consultation and engagement of our First Nations is recognized. This act and commitment of collaboration and inclusion demonstrated by the Chief Coroner is an important step in amending a system established for us, but without us. This creates the precedent and creates a pathway for continued opportunities to work together to improve and enhance policies and practices. This is the first of many transformations that must come for Canada and Ontario to upholds their obligations to advancing true Reconciliation and obligations required by the State under UNDRIP.

Chi Miigwecth

Linda Debassige,
Grand Council Chief
Anishinabek Nation

Message From Anishinabek Nation Children's Commissioner Duke Peltier

The Ontario Office of the Chief Coroner is taking a crucial step towards a more culturally appropriate and meaningful child and youth death review process by engaging directly with the Anishinabek Nation and its' citizens. The anticipated transformation will move us closer to implementing meaningful measures that will be more responsive to the families that are seeking answers in their time of grief.

Duke Peltier,
Anishinabek Nation
Children's Commissioner

Background

In 2023 the Ontario Chief Coroner reached out to the Anishinabek Nation to dialogue regarding transformation of the Child and Youth Death Review (CYDR) process. The Ontario Chief Coroner is seeking to transform the CYDR process to a more culturally appropriate and meaningful process for First Nations and to implement better prevention.

The Anishinabek Nation wanted to ensure that our Anishinabek First Nations had a voice in this transformation initiative. In the fall of 2023, with the support of the Office of the Chief Coroner (OCC), the Anishinabek Nation Legal Department hosted several engagements with our Anishinabek First Nations to receive expertise and guidance on what would be needed for the transformation of the OCC's CYDR process and to prevent tragic losses of our First Nations children and youth.

The Legal Department conducted several engagements to hear expertise and guidance from front line child well-being workers (i.e. prevention workers and band representatives, family well-being workers), cultural knowledge keepers and our Anishinabek First Nation leadership. We also ensured to invite representatives from each of our Nation Building Councils. We held some virtual engagements through Zoom, and as well four (4) regional hybrid engagements were held as outlined below:

- Virtual Engagement Child & Family Well-Being Workers - November 29th, 2023
- Virtual Engagement Child & Family Well-Being Workers - January 18th, 2024
- Southeast Region Hybrid Engagement – January 30th, 2024 (Orillia, ON)
- Northern Superior Region Hybrid Engagement – February 6th, 2024 (Thunder Bay, ON)
- Lake Huron Region Hybrid Engagement – February 27th, 2024 (Sudbury, ON)
- Southwest Region Hybrid Engagement – March 6th, 2024 (London, ON)

As well as an online survey was made available as an official engagement tool to collect feedback from First Nation Child and Family Well-Being Workers and leadership on key issues and recommendations related to transformation of the Child and Youth Death Review process. This survey was structured to be accessible and allow participants to provide their insights, concerns, and recommendations, ensuring that their input is formally considered in shaping recommendations to the Office of the Chief Coroner. The online survey allowed sharing for those who could not attend one of our engagements and feedback from the online surveys were included in the engagements dialogue overview and recommendations.

"I would like to begin by expressing my deep appreciation for the insightful presentations and valuable teachings shared during this session. Additionally, I am profoundly grateful for all references and acknowledgments made to Devon Freeman's Inquest. Every time I hear his name, it reassures me that his message is being conveyed through the recommendations.

I find myself struggling to formulate a specific question, so please bear with me if my inquiry seems basic. I am curious about whether adopting this approach could potentially lead to a reduction in the number of calls for an inquest. Based on my own experience, when my Nation was not included in a death review, we were left without clear explanations regarding the circumstances of Devon's passing. Ultimately, calling for an inquest was our only recourse to uncover what happened and to share our beliefs about the factors that contributed to his death."

Shannon Crate, January 30th, 2024
Chippewas of Georgina Island First Nation
Southwest Region Hybrid Engagement

"When we confront the traumas that resurface from deeply traumatic experiences, it's not just about facing hardships; it's about seizing a profound opportunity for healing and growth. This heightened emotional state can be transformative, allowing individuals and communities to delve into these experiences, understand them better, and perhaps find peace. It's essential that we provide robust follow-up support for our communities during these times. By doing so, we not only help them navigate their pain but also empower them to emerge stronger, turning a period of intense vulnerability into a catalyst for profound personal and communal healing."

Forry Hare, February 27th, 2024
M'Chigeeng First Nation
Lake Huron Region Hyrbid Engagement

"The inquest into the tragic passing of Devon Freeman from Georgina Island First Nation has yielded 75 critical recommendations. These are not mere suggestions, but imperative actions requiring immediate support, funding, and resource allocation from all levels of government. Devon's story is a sobering reminder of the systemic gaps — at just 16, while in care, he was let down by the system that was supposed to protect him. His life, marked by courage and resilience, underscores the urgent need for reform. The 75 recommendations provide us with a clear roadmap for change. I wholeheartedly endorse the implementation of Devon's principle, urging Ontario to legislate the right for First Nations youth and children to return to their communities — a fundamental right that must be recognized and affirmed."

Lance Copegog, January 30th, 2024
Eshski-Niigijig Advisory Council
Southeast Region Hybrid Engagement

What is a Child and Youth Death Review?

Child and Youth Death Reviews (CYDRs) are conducted in Ontario by the Office of the Chief Coroner (OCC). The OCC has an internal unit that is dedicated to the work required for CYDRs and investigations, referred to as the Child and Youth Death Review and Analysis (CYDRA) Unit. As stated at the Ministry of the Solicitor General's website, "*The goal of child and youth death review is to reduce child and youth deaths, make service-level, systemic, and structural recommendations aimed to prevent deaths, and to contribute to public safety by supporting recommendations that enhance the overall well-being of children, youth, their families, and communities. The purpose of child and youth death reviews is to explore the circumstances related to the child or youth's death in order to honour their lives, learn from them and make recommendations that may contribute to the prevention of further deaths.*"

Child and youth deaths are evaluated by the OCC and where it is determined that further review would be beneficial, deaths are reviewed by the OCC and its CYDRA unit. CYDRA reviews information from Serious Occurrence Reports, Child Fatality Case Summary Reports, and coroner's investigation statements as part of the decision-making process. A number of other criteria are also considered, including factors based on research and best practice. Some examples of the child and youth death review process that are implemented by the OCC are as follows[1]:

- Interim Paediatric Death Review Committee – Children and Youth (PDRC-CY) – Indigenous;
- Interim Paediatric Death Review Committee – Children and Youth (PDRC-CY) – Non-Indigenous;
- Local Reviews co-developed through First Nation-Led Protocols;
- Local Death Reviews Tables;
- Expert Reviews; and
- Other Death Review Processes (for example, case conferences)

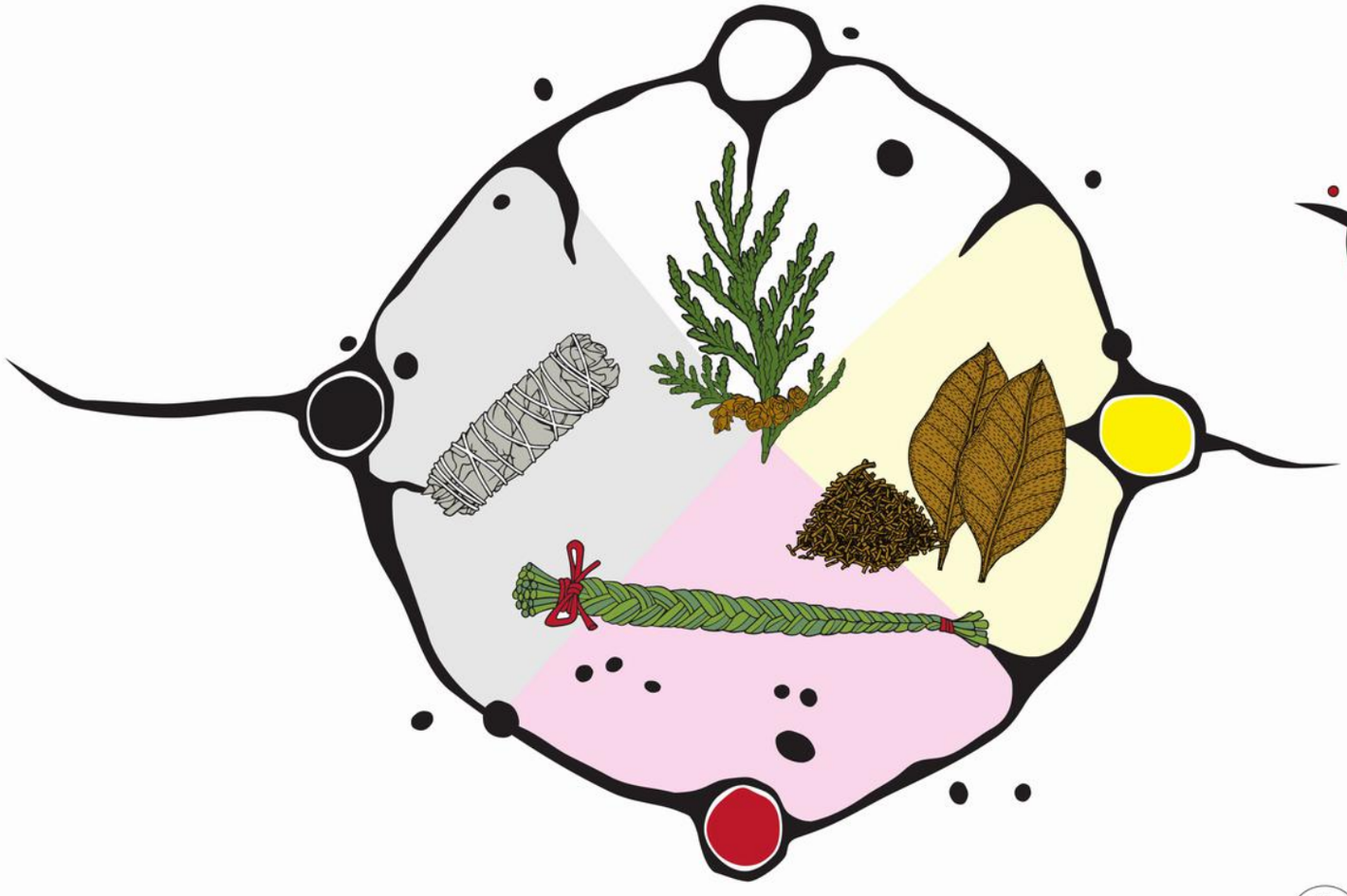
1. See more information at the Ontario Ministry of the Solicitor General website here https://www.ontario.ca/document/paediatric-death-review-committee-medical-and-child-and-youth-death-review-and-analysis-2019-2021/child-youth

For the purposes of our engagements and this report, we refer simply to Child and Youth Death Review (CYDR) and this could encompass any of the reviews mentioned above.

Additionally, due to a Joint Directive on Child Death Reporting and Review between the OCC and the Ministry of Children, Community and Social Services (MCCSS), coroners in Ontario investigate all pediatric deaths where a Children's Aid Society (CAS) or an Indigenous Child and Well-being Agency has been involved with the child, youth or family within 12 months prior to the death.

In its CYDRs, the OCC works with experts and sectors to determine who best participates in the review. Each death is unique in terms of the review process depending on the individualized factors related to the child or youth who has passed on and the circumstances involved within their experience.

The OCC understands that its CYDR processes have not been inclusive and meaningful for First Nations families and communities and, rather than being helpful, may have actually caused harms and further traumas to our First Nation families and communities. As mentioned above, the OCC is working to engage First Nations to learn more about what is needed to transform its CYDR process to be more culturally appropriate and meaningful for our First Nation families and communities.



Participants Dialogue – Expertise Shared From Our Anishinabek First Nations

Richard Assiniwe,
Anishinabek Nation Head Getzit
and Knowledge Keeper

The Anishinabek Nation Legal Department hosted several engagements that were designed to share information about the Office of the Chief Coroner's Child and Youth Death Review (CYDR) process and to dialogue directly with leadership, staff, elders, knowledge keepers and other expertise from our 39 Anishinabek First Nations to receive their expertise and guidance on recommendations they see needed for positive change to transform the CYDR process to make it more meaningful and respectful of Anishinabek First Nations children, youth, families and communities.

During the engagements, the participants were asked seven dialogue questions (see below).

1	Have you ever been involved with a child or youth death investigation or review? Do you have anything you wish to share about your experience?
2	What is needed for First Nations families and communities to feel respected by the Coroner's Office in the process of investigations surrounding a child/youth death?
3	What are some Anishinaabe death ceremonies & practices you know about (ex. songs, cedar baths, sacred fire, etc.)? How can the OCC better respect these within the Child and Youth Death Review process?
4	What supports would your First Nation need to develop its own CYDR process protocol directly with the OCC?
5	The recommendations that come from the CYDR process are non-binding. What are some ways we can have better implementation of CYDR recommendations?
6	What do you feel are the main issues that may result in harm/death to your First Nation's children/youth?
7	What is needed to prevent these harms/deaths?

Below is a summary of the dialogue and feedback that was shared from our Anishinabek First Nations during our various engagements:

Abinoojiinyag (Children)– Sacred Gifts From Creator

In our Anishinaabe culture, our abinoojiinyag (children) are considered to be sacred gifts from the Creator. We have a profound responsibility to care for these gifts and to honor them in both life and in their journey home (their death). It is essential for us to ensure that our children and youth remain deeply connected to our Anishinaabe ceremonies, cultures and communities throughout their lives and during their spirit passage home. Ceremony for the spirits of our children is just as important in their deaths as during their time here in the physical world.

Apology From the Chief Coroner

We know that the past processes for death investigations and CYDRs have not been inclusive and respectful of our First Nations families and communities. Ontario Chief Coroner, Dirk Huyer, recognizes this and is striving to transform the CYDR process to be more inclusive and meaningful for First Nations. It was expressed by participants within our early virtual engagements that an apology from the Chief Coroner was necessary to acknowledge the harm caused by the past processes. It was expressed that such an apology is a critical step in the Office of the Chief Coroner demonstrating accountability and responsibility for the harm caused by these exclusive and patriarchal processes. An apology would be a key step towards healing the relationship between First Nations and the OCC and to rebuilding trust.

During the hybrid regional engagements, Ontario Chief Coroner, Dirk Huyer, offered a heartfelt and sincere apology which is an important step toward healing and working together towards meaningful transformation of the CYDR process.

Reconciliaction

It was expressed during the engagements that First Nations need to see real actions and progress in changes to death investigations and CYDR. It was shared that the term "reconciliation" is often used as a buzzword in Canada since the release of the Truth and Reconciliation Commission's (TRC's) Report.

The TRC's final report included 94 Calls to Action meant to be actionable policy recommendations to aid the healing process for residential school survivors and First Nations through acknowledging the history of the residential school system and to create systems of preventing such abuses from ever happening again in the future. These calls to action cover various areas, including child welfare, education, language and culture, health and justice. It is the actionable measures that are essential for driving positive change towards reconciliation. Many First Nations people feel that the word reconciliation is often spoken about while the actual implementation of the actions often fall short of taking the steps needed to achieve it. First Nations want to see real, tangible actions being taken as evidence that true reconciliation is happening, rather than just hearing the words.

We heard from our Anishinabek First Nations that it will be important to see actionable steps by the OCC towards implementing the feedback and recommendations from these engagements.

Seven Grandfather Teachings

We heard about the importance of our Seven Grandfather Teachings in our Anishinaabe culture and that these teachings should be embraced as guiding principles for all aspects of death investigations and CYDRs. The teachings of Zaagidwin (Love), Debwewin (Truth), Mnaadendmowin (Respect), Nbwaakaawin (Wisdom), Dbaadendiziwin (Humility), Gwekwaadziwin (Honesty), and Aakedhewin (Bravery) guide our relationships with one another and all relations. These teachings are principles of Anishinaabe law and offer key foundations of wisdom, understanding, respect, and empathy that are crucial to honoring the lives and spirits of our people in their lives and in deaths.

It was recommended that the OCC adopt the Seven Grandfather Teachings as foundational principles within all of its organizational policies, processes, and training programs. The Seven Grandfather Teachings are very broad, but powerful, teachings that can be easily implemented into our daily lives and practices. Although these are considered to be Anishinaabe teachings, these principles can be easily understood by all nationalities and could help to foster strong foundations of empathy and compassion within the OCCs policies and approaches.

Respect for Anishinaabe Law and Jurisdiction

During the engagements, it was shared that it is essential for the CYDR process and death investigations to be founded upon inclusivity, empathy and a deep understanding and respect for diversity in worldviews. In Anishinaabe culture and worldview everything is interconnected and circular. Our Anishinaabe communities are guided by our own Anishinaabe laws since time immemorial and which help our spirits—both living and passed—achieve a good life, known in the Anishinaabe language as mino bimaadiziwin. Our ceremonies are fundamental to these laws. Our people have needs both in life and in death, and our ceremonies from the time of death are crucial in guiding the spirit on its journey home, as well as in supporting the family through their grief and healing. It is imperative that the Office of the Chief Coroner and other sectors and service providers respect and honor our Anishinaabe laws and our culture in their work. The OCC can learn more about each First Nation's specific practices and approaches through its protocol development work with each individual First Nation. As well, the OCC can implement this respect through legislative and policy change and internal cultural sensitivity training.

Our Anishinaabe ceremonies and customs are aspects of our Anishinaabe laws and it is important for death investigations and the CYDR process to be respectful and inclusive of Anishinaabe laws, customs and ceremonies surrounding the passing of our loved ones. It is of paramount importance that the death investigations and the CYDR processes do not delay or obstruct the implementation of Anishinaabe death ceremonies. These ceremonies are essential not only for helping the spirit of our loved one on their journey to the spirit world but also for aiding the grieving families and communities in their healing. This is crucial to honoring the lives and deaths of our First Nations children and youth.

Implementation of Recommendations From the Coroner's Inquest Into the Death of Devon Freeman (Muska'abo)

Devon Freeman (Muska'abo) was a youth citizen of the Chippewa of Georgina Island First Nation who had grown up living off-reserve in Hamilton, Ontario. Devon faced a lot of hardships and challenges during his young life. Devon's family was involved with the Children's Aid Society of Hamilton (CAS) several times during his upbringing. Tragically, his mother passed away when Devon was only just six years old and her death had a profound impact on him. Devon's grandmother took Devon and his sisters into her care and they did their best to move on from this tragedy. Devon had experienced difficulties in school from a young age; however, transitioning into his teens school became more difficult for him and he also experienced challenges with his mental health and suicidal tendencies. His grandmother did all that should could to try to seek services and supports that could help Devon. Devon needed access to services beyond the availability of what his grandmother could provide. He did access some services and supports while staying at a youth center in Hamilton called Jeb's place. It was during his stay at Jeb's Place that he had reported that he had attempted to take his life. Sadly, although Jeb's Place was providing some supports to Devon, stays at the center were not long term and Devon's stay period ran out. Devon's grandmother could not care for Devon at her home and there were no other options for Devon. The CAS became involved with the family. Devon was placed into extended society care and into another youth residential facility where he was supposed to be able to access services and supports that could help him with his educational and mental health challenges. Sadly, Devon did not receive the supports he needed at the residential facility where he was placed, including any culturally appropriate services and supports that are so important for our Anishinaabe youth. As well, there was a lack of communication within the CAS and the residential facility about Devon's history of reported attempt of suicide. Devon did not want to reside at the residential care facility and would often run away from the facility but, with nowhere else to go, eventually would return. Devon continued to report suicidal thoughts. His grandmother and his First Nation were never advised by the CAS or by the residential care facility about these suicidal issues that Devon had been experiencing. On October 7th, 2017 Devon left the residential facility and never returned.

Tragically, Devon's body was located on the grounds of the residential facility on April 16th, 2018, six months after he had gone missing. His death was deemed a suicide. Devon was just seventeen years old when he died. Devon's First Nation had not been notified about Devon's challenges in residential care, that he was missing nor of his death. It was not until June of 2018 that Chippewas of Georgina Island learned of Devon's death when his grandmother sent the First Nation a copy of his death certificate. Devon's death was a heartbreaking and unnecessary tragedy which has impacted all who knew and loved him. His first Nation community was devastated that they had not been notified about Devon's mental health and suicidal challenges to try to offer culturally appropriate supports to him and his family. His First Nation was also heartbroken that they were not notified of Devon's death to be able to offer ceremony for his spirit and supports for his family to help with their grieving and healing.

After Devon's death, in 2020 there was a Pediatric Death Review conducted by the OCC through a Pediatric Death Review Committee – Child Welfare. Chippewas of Georgina Island was not notified or invited to participate within this review. Devon's grandmother and Chippewas of Georgina Island filed a complaint and officially requested a Coroner's Inquest into Devon's death. They felt it was important for Devon's story to be investigated and told publicly to try to bring public awareness and systemic change to the public systems that should have been there to help Devon and his family but had failed him.

A Coroner's Inquest into Devon's death was held over four weeks in the fall of 2022. The inquest explored the circumstances of Devon's life and death, and considered ways to prevent future deaths in similar circumstances. The jury heard testimony from dozens of social and health services professionals, Indigenous advocates, family and community members. The Anishinabek Nation was granted standing in the Inquest as a public interest party. The Anishinabek Nation was able to engage our Anishinabek First Nations child and family well-being workers and band representatives to have them share their expertise and guidance on what changes need to happen to prevent deaths such as Devon's. A report of the recommendations from these engagements was entered as evidence at the Inquest hearing. At the conclusion of the Inquest, the jury made 75 recommendations towards various service providers, including the OCC.

It is imperative that we honor Devon's life and death through follow up on the recommendations that came from the Inquest to make needed changes to prevent similar harms and deaths of other children and youth. It is recommended that the OCC take actions, including legislative measures where needed, to support the full implementation of all 75 recommendations from the Coroner's Inquest into the death of Devon Freeman (Muska'abo). To highlight a few of these recommendations, they include formalizing immediate notice to First Nations when one of our youth goes missing, incurs serious harm or death; including the family and Indigenous community of the deceased in the death review process; and reviewing the discretionary nature of inquests into the deaths of children in care and consideration of advocating for legislative change that these deaths be subject to mandatory inquests.

Notice to First Nations and First Nations Participation

Our Anishinaabe communities hold expertise, unique gifts and invaluable insights that are absolutely essential to death investigations and the CYDR process where our First Nation citizens are involved. We know that the death investigation and CYDR processes have tended to lack the direct involvement and inclusion of First Nations in death investigations and CYDRs. There have been instances when a First Nation may not have been notified at all that one of their children or youth have passed and death investigations and CYDR processes have occurred about the child or youth. These instances have been heartbreaking for our First Nations who find out about these deaths and reviews much later through family or other communications. When a death of a First Nations child or youth occurs, this impacts the whole community. First Nations want to be offered the opportunity to offer ceremony and other supports to the spirit of the child or youth that has passed and also to help the family and community with its healing process.

It was communicated very clearly during the engagements that First Nations must receive immediate notification from the OCC about the death of any of our children or youth. Additionally, the OCC needs to ensure early, ongoing and regular communications with the family and the respective First Nation to provide ongoing updates on the status of the death investigation, forensic results, and other relevant matters.

Immediate notification is crucial for First Nations to implement key ceremonies from the time of death which are essential to support the spirit of the child or youth on their journey to the spirit world and to help the grieving family and community in their healing process. Timely notice and early and ongoing inclusion of First Nations within the death investigation processes will address many of the concerns First Nations have with the OCC's death investigation and CYDR processes by ensuring the following:

Respect for First Nations jurisdiction and laws:
These are our children and youth, and our jurisdiction and laws must be respected. Our death ceremonies and protocols are integral parts of Anishinaabe law and should be honored accordingly. Our Anishinaabe death ceremonies and practices are an important aspect of honoring the spirit of our loved ones to help them on their journey home and are also important to helping the family and community to heal. Some of these ceremonies are to be commenced for the spirit at the time of death and involve other important timeframes (ex. sacred fire, pipe ceremony). It is crucial that First Nations are provided immediate notice about the passing of one of our children or youth and offered the opportunity to be involved to implement ceremonies and practices that are important to honor the spirit of the child or youth and to help support the family and community members in the grieving process.

Respect for the diversity of each First Nation:
Every First Nation has its own unique approaches to death ceremonies and supports that it can offer. Involving the First Nation of the child or youth early and directly within the death investigation and CYDR processes can help to ensure that the diversity of our First Nations is respected.

Involvement of the First Nation's Elders:
We heard feedback that an Elder from the child or youth's First Nation should be involved from the outset to provide guidance on the ceremony to be offered and other supports for the family and community. Immediate notification and ongoing direct involvement of the First Nation will allow the First Nation to connect with one of their Elders to help with these tasks.

Support for grieving families and communities:
First Nations should be able to have the opportunity to offer supports to the grieving family and community members, including facilitating communication between the OCC and the family, providing ceremonial supports, assisting with funeral and burial arrangements, offering mental health counseling, and advocating in the CYDR process. Immediate notification and ongoing direct involvement of the First Nation will help the First Nation in its ability to provide supports to the grieving family and community (before, during and after any death investigations and review).

It is recommended that the OCC take immediate steps to formalize the process of providing immediate notice to First Nations of the death of a child or youth and to involve First Nations in the death investigation and review process from beginning to end of these investigations and reviews. This involvement should include providing First Nations with the ability to offer ceremonial supports to the spirit of the passed loved one, supports for the family, and guidance on how any CYDR should proceed, including the development of any CYDR related reports and recommendations, and follow-up on the implementation. The OCC should take immediate steps to implement this recommendation through formal mechanisms, such as updated mandates to local and regional coroners; updated forms and databases; updated OCC policies, updated directives in collaboration with the Ministry of Children, Community and Social Services (MCCSS) and other ministries.

The OCC must also ensure that regular and ongoing communication is maintained between the OCC, the family, and the First Nation. Various recommendations, such as the position of a First Nation Liaison or Navigator within the OCC (see more details about this recommendation below) could be supportive to the OCC in this task. The Child Fatality Case Summary Report (CFCSR) and Serious Occurrence Reports (SORs) used by the OCC and MCCSS should be updated immediately to include sections that capture information about the following: whether the child or youth is connected to

a First Nation(s); which First Nation(s) they are connected with; whether the First Nation was notified; and the details of this notification. Local and Regional Coroners should be required to gather this information and include it in the death investigation related forms, reports and the databases used (ex. QuinC).

In addition to all of the above, there is also a need for legislative reform to support the requirement for immediate notification and involvement of First Nations. The OCC must recognize and respect that, in Anishinaabe culture, the death of a First Nations child or youth affects not just the family but the entire community. First Nations communities have a collective nature and a distinct role in matters concerning our children, youth, and families. General concerns about privacy should not hinder the OCC's notification to First Nations about the death of a First Nations child or youth. The notification requirements set out in the *Child, Youth and Family Services Act* (*CYFSA*) and the *Act respecting First Nations, Inuit and Métis children, youth and families* (also known as C-92) regarding child protection matters provide an example where mandatory notification to First Nations is already in place and could serve as a model for the OCC in cases of child or youth deaths.

Mandatory and immediate notification allows First Nations to appoint representatives to work with families to offer supports. While families can refuse support from the First Nation, the opportunity for the First Nation to offer supports is essential.

As well, the OCC must acknowledge that a First Nations child or youth may be affiliated with more than one First Nation. If this is the case, both First Nations should be notified and offered the opportunity to be involved in the process.

Children and Youth On and Off Reserve

The current CYDR process is flawed when it comes to identifying whether a child or youth involved is from a particular First Nation and also in including First Nations children and youth who may reside off reserve within the CYDR process. Typically, under the current death investigation and CYDR process, the OCC only becomes aware of a child or youth's connection to a First Nation if the death occurs at an address on a reserve or through information provided by service providers such as Children's Aid Societies (CAS) regarding the child or youth's First Nation status. Due to colonial policies and systemic issues (i.e. lack of housing, employment, health, education and social services), many First Nations children, youth, and families reside off reserve. Anishinabek First Nations want to be able to provide supports to our children, youth and families regardless where they may reside.

The identification aspect of the CYDR process presents challenges for First Nations to be notified of the death of one of its children or youth early in death investigation processes. A First Nation must be notified and involved in the death investigation or review of any of its children, irrespective of where the child or youth resided. It is important for the First Nation to receive this early notification to be able to offer culturally appropriate supports for the spirit of the child or youth who has passed (ex. ceremony) and to offer the family with various supports to help them through the difficult time.

It is absolutely crucial for the OCC to implement steps to transform its death investigation and CYDR processes to ensure that there are steps taken at the outset to identify whether a child or youth who has passed has a connection to a First Nation regardless whether or not they reside on or off reserve to ensure that notification is provided to the First Nation about the death. Local Coroners are one of the earliest on the scene of a death and must be tasked with the responsibility for investigating and gathering information about whether a deceased child or youth has a connection to a First Nation. Local Coroners should also be tasked with providing notification to the First Nation of the circumstances.

Children and Youth Up To the Age of 26 Years Old

The current Pediatric/Child and Youth Death Review process is only inclusive of children and youth between the ages of 0-19 years old. However, the provincial government provides funding for youth in transition from care up to the age of 23, and the federal government offers First Nations Child and Family Services (FNCFS) post-majority support services funding for First Nations youth and young adults up to the age of 26 years old.

If child welfare related services and supports were being provided to a First Nations child or youth who has passed, it will be important for those aspects to be reviewed within the CYDR process. It will be important for the OCC to transform its CYDR process to be expanded and inclusive of First Nations youth up to the age of 26 years old.

Inclusion of Children and Youth Regardlessof *Indian Act* Status

Many First Nations children and youth, although eligible, may not have been registered for status under the *Indian Act*. Additionally, some First Nations children and youth may be recognized as citizens of their First Nation although they may not qualify for *Indian Act* status. Regardless of their status under the *Indian Act*, it is essential that First Nations children and youth are identified through the death investigation process and the First Nation is notified concerning the loss of one of its members. The OCC must ensure that First Nations are included in the death investigation and CYDR process, regardless of whether the First Nation child or youth lacks status under the *Indian Act*.

Similar to the feedback above regarding on and off reserve children and youth, it is important for the death investigation and CYDR processes to be transformed to be inclusive of all First Nations children and youth recognized by the First Nation. Local Coroners must be tasked with the responsibility to investigate and determine whether a child or youth who has passed has connection to a First Nation regardless of whether they have *Indian Act* status.

Transformation of Death Investigation and CYDR Forms

The OCC's death investigation database (QuinC) and the Child Fatality Case Summary Report forms do not include or require sufficient information to be entered to fully identify First Nations children and youth, which First Nation(s) the child or youth belongs to and whether or not the First Nation has been notified of the death to be involved in the death investigation or CYDR processes.

We heard feedback from participants that the OCC should actively advocate for dismantling the colonial and systemic barriers that affect exclusion of First Nations within its processes. It is crucial for the OCC to update its internal forms (such as the CFCSR) and databases (such as QuinC) to ensure that all First Nations children and youth are accurately identified and First Nations are notified of the deaths regardless of the child's residency or *Indian Act* status. Any death investigation and review related forms and databases must ensure that those involved with completing the forms and entering information into the database(s) have completed investigations to determine whether a child or youth has a connection to a First Nation, what First Nation(s) the child belongs to, notification that has been provided to the First Nation and any details surrounding this notification.

First Nations Liaison/Navigators Within the OCC

We heard from participants that the Office of the Chief Coroner (OCC) is not effectively addressing the needs of First Nations, and there is a lack of regular and ongoing communications with the families and the First Nation in death investigations and in the CYDR process. Our Anishinabek First Nations recommended the creation of First Nations Liaisons or Navigators within the OCC. These positions could help to provide the focus and attention the OCC needs to provide for First Nation families and communities where death investigations and reviews for our children and youth are involved. We heard feedback that the Missing and Murdered Indigenous Women (MMIW) initiative had a dedicated team in Ontario through the Family Information Liaison Unit (FILU), which successfully built relationships and trust while supporting families in navigating interactions with police, coroners, and other involved parties. The FILU often met with First Nation representatives and families in the communities and in urban areas to facilitate this process. The Anishinaabe term for helper is oshkaabewis. An oshkaabewis such as a First Nation Liaison or Navigator is needed within the OCC to help support ongoing communications and participation of First Nations and families within the OCC's death investigation and review processes. The following were some further guidance received during the engagements about the role of a First Nation Liaison/Navigator (oshkaabewis):

- Possibly having one or two First Nation Liaisons in each region who work directly with the First Nations in their area.
- Considering a regional team approach, where each region could have a First Nations Liaison team that includes a main liaison and a cultural worker, among others.
- Rebuilding trust and relationships between First Nations, families, and the OCC. Trust has been eroded, and there is a sense that local authorities do not take the concerns of First Nations victims seriously and often try to silence their stories. It is essential for First Nations Liaisons to rebuild and maintain this trust for the families and communities, and the OCC must support this by improving communication.
- First Nations Liaisons could be helpful to the OCC in developing protocols with First Nations for death investigations and CYDRs that respect First Nations customs and practices.
- First Nations Liaisons could be helpful to ensuring early, regular, and timely communication, and helping First Nations and First Nations families better navigate the investigation process with local coroners and service providers such as Children's Aid Societies, police, hospitals, and educational institutions.
- Supporting the OCC in implementing First Nations protocols and guiding the process in collaboration with First Nations when a child or youth death occurs.
- The First Nations Liaison can be helpful to an approach which emphasizes the need to gather, learn, and build trust together, symbolized by the importance of coming together on the land, around the fire.

Improve Recruitment of Local Coroners and Other Internal Staffing

During our engagements, it was shared by the OCC that there is a shortage of local coroners in Ontario and definitely a shortage of Indigenous local coroners. The OCC faces several challenges in recruitment of local coroners. Unfortunately, medical school graduates tend to gravitate towards other areas of practice such as general practice or specializations in other fields. As well, a career as a local coroner is very demanding and on-call and after-hours work. Those practicing as a local coroner may be called to the scene of a death at any hour of the day. Some local coroners are working in these positions in addition to their general practice, and this work can be very intensive and time-consuming work. As well, the shortage of local coroners seems also to cause many local coroners to have to travel long distances to be on scenes in other regions of the province when a local coroner for that region may not be available. The local coroner attending the scene may not be able to get to the scene as quickly and may not be familiar with the local First Nations community and their protocols.

We heard that there is a need for more local coroners across the province and local coroners available in geographically remote areas of the province to be able to address death investigations in those remote areas in a more timely manner. If there were more local coroners and pathologists available in each of the regions of the province, this could be helpful to speed up wait times on investigations. Higher recruitment of local coroners for each region to devote time specifically to their local region and to become more familiar and build relationships with the communities in the particular region they serve would be a meaningful change.

We heard from our Anishinabek First Nations that it is very difficult for families of a passed loved one to have to wait long periods of time for death investigations and forensics to be completed before they can conduct ceremony for their passed loved one. Our Anishinabek First Nation communities in the remote north are especially impacted by long timelines when the body of their passed loved one is required to be transported for autopsies and forensics in more southern locations of the province. This is very traumatic and difficult for the grieving loved ones and the communities. We heard from the engagements that there is a need for local coroners and pathology to be situated and available in the remote northern regions of the province and the need for coroner and pathology teams to be available to conduct their investigations in the north rather than having to transport a loved one's body to southern Ontario.

In addition to better recruitment for local coroners, we also heard that the OCC also needs better recruitment of other internal staff who can assist in moving death reviews and inquests along faster than currently. The Chief Coroner had mentioned that there are many cases throughout Ontario (not only First Nations circumstances) that are awaiting to see if they require death review or coroner's inquests. This backlog needs to be addressed. Our First Nations families and communities should not have

to wait the extensive length of time it currently takes to receive word from the OCC about whether a death review or inquest will take place surrounding their loved ones passing.

The OCC should review its recruitment efforts and see where it can take steps to improve and increase the recruitment of local coroner teams in each of its regions, as well as other staff needed internally at the OCC to assist with the backlog surrounding death reviews and inquests. It will be important for recruitment of the First Nations Liaisons mentioned above to be established as an aspect of these efforts.

Protocol Development and Capacity Funding for Meaningful Participation

In recent years the OCC has commenced work with a few Anishinabek First Nations who have tragically experienced a child or youth passing to develop protocols between the First Nation and the OCC on the process for CYDR. These protocols can help to ensure that when a CYDR is implemented it is culturally appropriate to the First Nation and guided by the needs of the family and the community. These protocols have helped the OCC and First Nations to implement a more meaningful and culturally appropriate process from what has been used for CYDRs in the past. The OCC has expressed interest in ensuring that such protocols are developed with each Anishinabek First Nation and this was something we heard Anishinabek First Nations would like to see available. Our hope is that these sorts of protocols would never need to be implemented surrounding the death of one of our children or youth. However, if such a death does occur, having these protocols already developed can help the OCC and the First Nation to have a clear process in place to guide death investigations and the CYDR process in ways that can support the family and community in the best ways possible during such a difficult time of grief.

It is important to emphasize that a pan-Indigenous approach should not be applied by the OCC in death investigations and reviews. Each First Nation has its own unique laws and practices that must be respected. Protocol development with the OCC can help to ensure that each First Nation's practices and approaches are respected during the community's time of need. These protocols are essential for fostering positive relationships between the OCC and First Nations and are in ensuring that the OCC respects the diverse approaches each First Nation has regarding death ceremonies, protocols, and supports.

Throughout the engagements we heard that First Nations will require capacity funding to meaningfully participate in both proactive protocol development and also to participate meaningfully within death investigations and CYDR processes should a death ever occur. First Nations communities are significantly underfunded and understaffed in many areas. To create meaningful and effective protocols for death investigations and reviews, First Nations will need capacity funding to engage their staff, families, and communities in the development of these protocols. It is crucial that

the community level is actively involved in shaping these protocols to ensure they are truly reflective of the community's needs and values. This funding will empower First Nations to create protocols that honor the spirit of a child or youth who has passed, to implement the unique cultural practices of the community and to provide supports to the families and the community during times of loss.

First Nations will also need to be funded to implement their protocols should a child or youth death arise. As well, capacity funding should account for the unique challenges faced by remote communities, ensuring that they are adequately supported (see more below).

Special Considerations for Our Remote Communities

We heard how the transportation of our passed loved ones to southern cities for death investigations and forensic pathology is extremely difficult on our families and causes delays in death investigations and traumas and harm to our communities. As well, the geographical remoteness of many of our Anishinabek First Nation communities can also lead to delays in local coroners taking longer to reach the scene of the death. These issues can result in prolonged and delayed process…sometimes taking many weeks before the body of a passed loved one can be brought home for burial. These delays cause postponement to vital ceremonies that are important to support the loved one's journey and to support the grieving and healing process for the family and community.

Additionally, remote First Nations face challenges and extra expenses when accessing services or traveling to participate in functions outside of their communities. Remote First Nations will require additional remoteness funding to be able to participate meaningfully in the development CYDR protocols and in any death review processes that may occur if one of our children or youth passes away. Where a CYDR is needed, the OCC should always offer the opportunity to hold these reviews within the First Nations community.

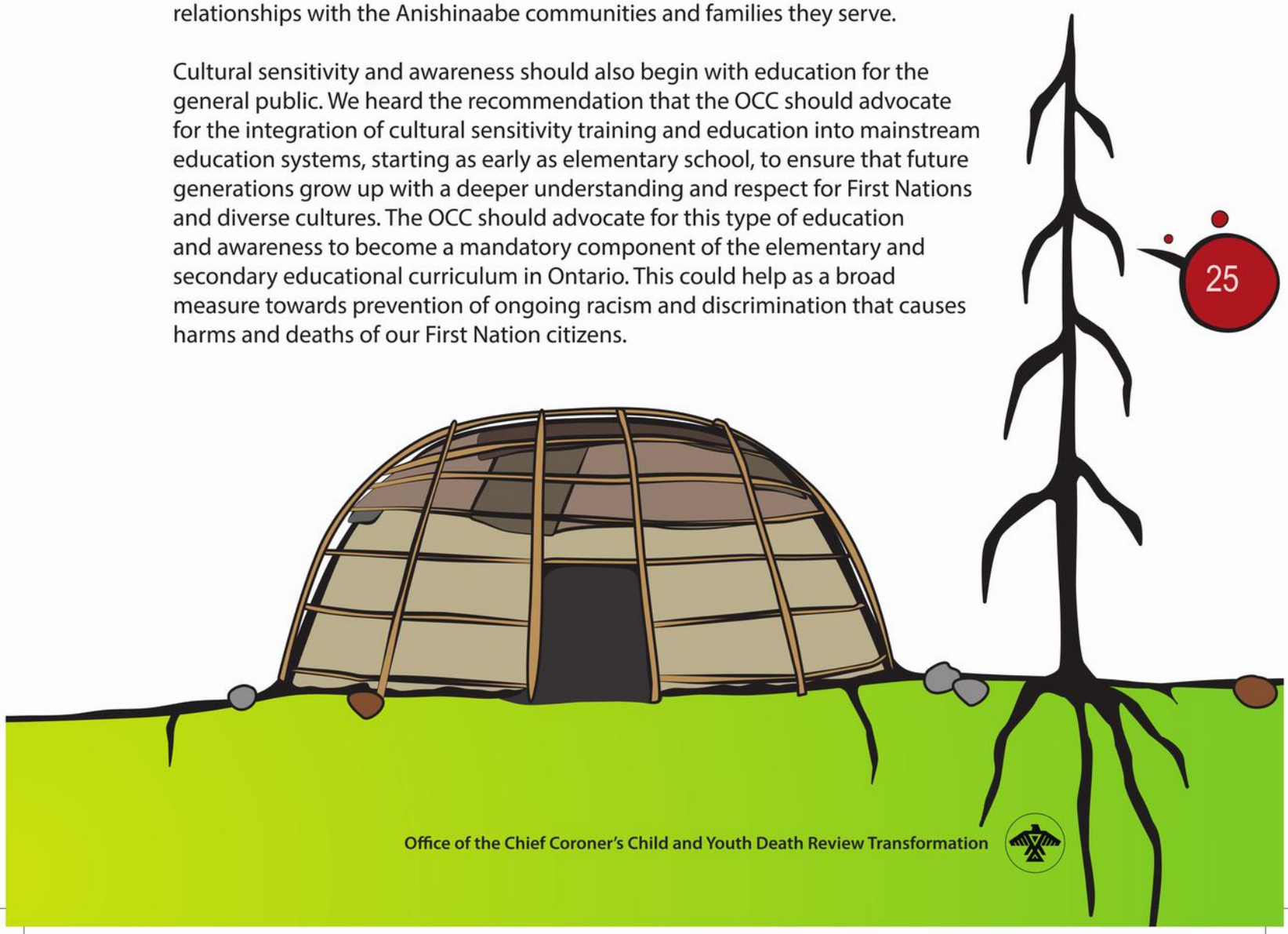
Cultural Sensitivity Training and Advocacy

First Nations communities have a deep distrust of mainstream service providers, including the Office of the Chief Coroner (OCC). This distrust stems from a long history of trauma caused by colonial policies and systems which continue to persist into modern day. First Nations citizens and communities continue to face racism and discrimination from the very systems that are supposed to protect and care for our citizens, such as policing, healthcare, child protection, and education.

The OCC has a responsibility not only to acknowledge the systemic racism and bias that exists, but also to take concrete steps to address and eliminate this discrimination to prevent further harms and deaths. There is a need for greater learning, empathy, and cultural sensitivity within the OCC and other sectors. The OCC must begin from a place of respect, humility, and empathy in all its interactions with our First Nations citizens, families and communities.

During the engagements, we heard that there is a need for the OCC to implement more meaningful cultural sensitivity training for all of those who work within the OCC, as well as for the OCC to promote cultural sensitivity training and trauma-informed approaches to be applied broadly within other mainstream systems and service sectors. This training is crucial for fostering an understanding and respect for First Nations cultures. It was expressed during the engagements that all who work within the OCC should be required to undergo mandatory cultural sensitivity training and that this training should incorporate the Seven Grandfather Teachings, trauma-informed approaches, cultural safety principles and aspects of learning first hand with First Nations in land-based training approaches. It is essential that OCC staff and others working within the OCC understand the foundations of Anishinaabe culture to build positive relationships with the Anishinaabe communities and families they serve.

Cultural sensitivity and awareness should also begin with education for the general public. We heard the recommendation that the OCC should advocate for the integration of cultural sensitivity training and education into mainstream education systems, starting as early as elementary school, to ensure that future generations grow up with a deeper understanding and respect for First Nations and diverse cultures. The OCC should advocate for this type of education and awareness to become a mandatory component of the elementary and secondary educational curriculum in Ontario. This could help as a broad measure towards prevention of ongoing racism and discrimination that causes harms and deaths of our First Nation citizens.



"When we're taught to write our investigative reports, it used to be you'd write 'the decedent.' You don't give them a name, and it's a hard thing to reconcile because that person was more than a decedent. They were someone loved, someone's child, no matter how old they were. They had many titles, and 'decedent' doesn't even come close to what they should be called. Sometimes you'll see 'the decedent,' and that hurts me because that's not how we do it. In our culture, we don't often say the deceased person's name, but we still feel them. That's where, when we talk about the Anishinaabe view of death, it becomes more meaningful."

Dr. Annelind Wakegijig

Insensitivity in Communications and Report Writing

Some reports from local and regional coroners may be accessible to be reviewed by grieving family members and the First Nation involved. It had been shared within our engagements that some of the terminology and approaches used in report writing by coroners and other service providers involved in death investigations and reviews are not appropriate and can, at times, be disrespectful and dishonorable to the spirit of the loved one who has passed and re-traumatizing for the family. For example, it has been noted that reports frequently refer to the "decedent" which seems a very cold and clinical term rather than acknowledging the person as a "loved one". As well, reports often focus solely on the circumstances of the death, with little to no information about who the person was in life—someone who was cherished and loved by their family and community. We heard that these approaches need to change. Additionally, reports sometimes include unnecessary and harsh descriptions, such as comments about a home being "filthy" or "filled with garbage," which do not contribute to understanding the cause of death and can be hurtful and re-traumatizing for grieving families. These circumstances are not mindful approaches and can be especially insensitive to families grieving the loss of a child or youth.

This insensitivity in communication and report writing reflects a lack of empathy for the families who may read the reports and a lack of awareness and understanding of Anishinaabe culture. The language used by coroners, and by other service providers such as CAS, police, and hospitals, when communicating and reporting about our Anishinaabe people must change to reflect a more compassionate and culturally informed approach. It is essential that any reports written by those involved with death investigations and the OCC be done so with a trauma-informed and culturally sensitive perspective. The OCC has a responsibility to tell the stories of those who have passed, especially children and youth, in a way that honors their memory. These reports are part of the person's legacy, and the loved one who has passed deserves to be remembered with respect and dignity. As was shared during our engagements, when it is too late to make

a difference in the person's life, coroners and others investigating should strive to make a difference in how their death is understood and remembered.

It is recommended that all staff and others who work within the OCC receive mandatory cultural sensitivity training, including training on culturally sensitive and trauma-informed report writing approaches. Coroners should also be required to seek information from the family, caregivers, and the First Nation about the loved one who has passed, so that they can write reports that honor the person's life and who they were, rather than relying on a cold and clinical approach.

Multi-Sectoral Child and Youth Death Reviews

Currently, the OCC's involvement in CYDRs is heavily focused on Children's Aid Societies (CAS) and deaths involving children and youth in care (or who had received services from a CAS in the year leading up to their death). This is largely due to the Joint Directive between the OCC and the Ministry of Children, Community, and Social Services (MCCSS). We heard that it is important for the CYDR process to recognize that the harms and deaths of First Nations children and youth are often influenced by a wide range of sectors and systems beyond child protection. As noted earlier in this report, the goal of child and youth death review is "*to reduce child and youth deaths, make service-level, systemic, and structural recommendations aimed to prevent deaths, and to contribute to public safety by supporting recommendations that enhance the overall well-being of children, youth, their families, and communities*." It is essential that the CYDR process directly involves and reviews a broader range of sectors which may have impacted on the death of a First Nations child or youth.

It is recommended that the OCC take steps to broaden the scope of CYDRs, particularly for First Nations children and youth who are impacted by systemic traumas and discrimination. CYDRs should directly include other sectors such as justice, corrections, health, policing, education, and more. By expanding the CYDR process to consider the impacts of these various systems, the OCC can better understand and advocate more meaningful changes to the complex factors that contribute to the harm and deaths of First Nations children and youth.

CYDR Follow Up and Recommendations Implementation

It has been expressed that there have been far too many deaths, and that the recommendations that come from death reviews and inquests often do not receive follow-up from the OCC to accurately assess what recommendations have been fully implemented or not and what, if any, real change has occurred to prevent similar circumstances and deaths. It was shared that service providers who receive recommendations from OCC processes such as CYDRs and inquests should be held more accountable to take action on recommendations, should be monitored independently surrounding recommendations implementation (rather than self-reporting), and, where First Nations are involved, should be required to follow up directly with the First Nation to report on the steps taken towards implementation. Below are some additional ideas that were shared surrounding strengthening implementation of recommendations that come from OCC CYDRs and inquests:

- It should be mandatory that First Nations are directly involved in the CYDR process, including the formulation and follow up of recommendations. As well, it should be mandatory that all reports and recommendations that come from the CYDR be shared with First Nations;

- A follow up circle could be held some time after the death review is completed and the report and recommendations have been shared with First Nations and others. This circle would bring together all those involved to report on the progress of implementing the recommendations. The OCC should take the lead in collaborating with the First Nation involved to plan these follow up circles;

- First Nations will need capacity support to designate a lead point of contact who can share the recommendations from the CYDR with the family, First Nations leadership, staff, departments, and the broader community. This point of contact would also help to plan follow up (ex. follow up circles) and track the implementation of recommendations by service providers such as CAS, health services, police, and others, ensuring accountability; and

- There should be follow up circles or meetings held as review annually to evaluate whether the recommendations have been fully implemented and if they are effectively contributing to positive change.

The OCC has a profound role and responsibility to honor the memory of our passed loved ones by carrying their message forward to create systemic change for our children and youth. The OCC must not shy away from the truth. To ensure effective and positive change for prevention, the OCC needs to improve its tracking and reporting on the implementation of recommendations. These steps are crucial to ensure that recommendations from CYDRs lead to meaningful and lasting improvements, honoring the lives of those who have passed and supporting the well-being of the family and community.

OCC Reporting and Legislative Review and Amendments

The Office of the Chief Coroner strives to release publicly available annual reports on its Child and Youth Death Reviews. It released a 2019-2021 report earlier this year which grouped together several years due to the COVID-19 pandemic. It is currently working on its 2022/23 report. The OCC is also working to incorporate OCAP® principles into its annual reporting.

During the engagements, it was shared that government reports are often written in formats that are very technical and difficult to understand. It was recommended that the OCC ensure that its annual reports are written in plain language, as if speaking with an Elder over tea. These reports should also be framed in a way that allows First Nations leadership, technicians and others to easily use the content of the reports in their public advocacy efforts to drive positive change.

It was also recommended that the OCC include in its annual reports a summary of the general recommendations made across all Child and Youth Death Reviews (CYDRs) in a given year, with a five-year review and report to assess what has been implemented from all of those recommendations.

In addition to the above, we received updates from the Chief Coroner during the engagements that the *Coroner's Act* may soon be undergoing legislative review. In any legislative reviews of OCC related legislation, the OCC must ensure that First Nations voices are heard and recommendations for legislative change are meaningfully integrated into the legislation and any regulations. The recommendations from within these engagements that relate to the *Coroner's Act* should be used to make legislative change.

The *Coroners Act* should recognize and implement the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)* to ensure Indigenous rights are upheld in processes like the Child and Youth Death Review (CYDR):

1. *Participation in Decision-Making (Article 18)* - First Nation families and communities must be actively involved in the review processes.

2. *Cultural Sensitivity (Articles 11, 31)* - Traditional cultural knowledge and practices must be integrated into investigations and preventative measures, respecting cultural heritage.

3. *Self-determination (Article 3)* – First Nation communities must have authority in decision-making related to death investigations.

4. *Access to Information (Article 27)* – First Nation families must have transparent access to information and participation in the review process.

5. *Data Sovereignty (Article 31)* - First Nation communities and community member's data must be controlled by their communities, respecting their rights over information.

6. *Reconciliation and Accountability (Article 22)* - The *Coroner's Act* must address the disproportionate deaths of First Nation children and youth, ensuring justice and accountability within the *Coroners Act*.

The above ensures the OCC's processes align with *UNDRIP*, advancing First Nations rights and reconciliation.

Our Anishinabek First Nations also expressed that First Nations need funding to support their advocacy efforts in regards to ongoing CYDR transformation and legislative reviews of the *Coroner's Act*. It was suggested that the Anishinabek Nation should be provided with resources to establish a hub that can advocate for and facilitate the sharing of this critical information amongst Anishinabek First Nations. This would honor the legacy of the children who have passed on.

Local Coroner's Timely Access to Key Records

It was communicated through the engagements that coroners sometimes face difficulties in timely access to key records from Children's Aid Societies (CAS) and other service providers. These records are needed for a local coroner to conduct their investigations and are needed in a timely manner. When there is not timely access to records and reports that a coroner needs to review, this delays the investigation process and causes stress and trauma to the family and First Nation community who need answers.

Additionally, it was noted that the process of sharing records could be improved if service providers offered them in an electronic format rather than as hard copies. These delays in accessing records can hinder a coroners' ability to complete their investigations promptly, leading to further issues with trust and relationships with the family and community.

It is recommended that the OCC collaborate with the Ministry of Children, Community, and Social Services (MCCSS) and other relevant sectors to develop more efficient protocols and practices to provide those who work within the OCC with more timely access to CAS records and other key records. It was discussed that where a CAS is involved in a death investigation and review, allowing local coroners access to the CAS's CPIN database could be particularly helpful in expediting this record sharing process.

More Efficient Data Gathering and Assessment

The OCC cannot make meaningful recommendations for the prevention of deaths of our children and youth if the OCC is not accurately collecting and assessing the data it needs to provide answers about whether the child or youth was First Nation and what the harms and causes of death were. The OCC currently uses the Child Fatality Case Summary Report (CFCSR) forms and the QuinC database to collect and store information related to deaths. Local coroners and others involved in death investigations input their reports and relevant details into these systems. The QuinC database contains templates designed to gather statistical data and other information about the manner of death.

The current system of gathering and assessing the data surrounding the deaths of First Nations children and youth is not adequate. For example, current data collection and tracking by the OCC is inadequate for accurately capturing how many First Nations children and youth have passed, the causes of their deaths, and whether the OCC's work is actually contributing to positive changes in preventing these deaths. Several factors contribute to this lack of comprehensive data, such as not having investigation and data collection processes in place to ensure the inclusion of off-reserve First Nations children and youth, or those who are unregistered or non-status, within the data. Additionally, the forms currently used by the OCC, such as the Child Fatality Case Summary Report (CFCSR) forms, do not require local coroners or others involved to include essential information that would identify a child or youth as belonging to a First Nation, regardless of their residency or *Indian Act* status. The forms also fail to track whether notice was given to the child or youth's First Nation and the details of that notification. It is crucial to address these gaps for future data collection and analysis that is key to prevention.

The OCC recognizes that its data collection has not been sufficient to track First Nations child and youth deaths, understand the causes, and monitor the uptake of recommendations to lead to effective prevention measures and advocacy. The OCC advised that it is collaborating with Chiefs of Ontario on data governance to identify patterns and to ensure First Nations communities have access to demographic information. However, the OCC currently lacks data on provincial trends related to First Nations deaths, acknowledging that its current data tracking and monitoring are insufficient. The OCC is cautious about releasing information that may be based on inaccurate data to avoid causing further trauma. The OCC's Child and Youth Death Review and Analysis (CYDRA) Unit, along with epidemiologists and data experts, are exploring ways to improve this, and there is an open invitation for all First Nations to be involved in the process.

It was shared by our Anishinabek First Nations during the engagements that the OCC should engage with the Anishinabek Nation to develop and implement a new and improved system of data gathering and governance. This system should ensure that key data that is needed for prevention of harms to our First Nations children and youth is collected and monitored accurately and in alignment with the principles of OCAP (Ownership, Control, Access, and Possession) and First Nations data governance.

OCC Indigenous Team/Unit

Given the many challenges that the OCC faces with regards to improving death investigations and reviews for First Nations peoples, it is recommended that the OCC take steps to establish an internal Indigenous team or unit within the organization that can help with implementing the above recommendations and needed changes. This dedicated team would be instrumental in addressing the unique needs and concerns of First Nation communities, ensuring that First Nation perspectives and cultural practices are fully integrated into the OCC's processes and operations. Developing this sort of unit would be key to positive change and Reconciliaction.

Prevention

Prevention is a fundamental aspect of the OCC's CYDR process. During our engagements we held dialogue with our Anishinabek First Nations to have them share ideas about what some of the main issues are which cause harm to our First Nations children and youth, and to seek guidance on what they see as what they see as important needs to prevent these harms. Below is a summary of several key measures Anishinabek First Nations feel are needed to prevent harms and deaths of our First Nations children and youth:

- *Implementation of all 75 recommendations from the Coroner's Inquest into the Death of Devon Freeman (Muska'abo)*: This was brought forth as a prevention need throughout our engagements and is discussed above. It is a crucial prevention measure that action be taken to implement all 75 recommendations from the Inquest. Not only would implementing these recommendations help to honor Devon's spirit, but they are also crucial to prevention of similar deaths of our children and youth in the future.

- *Capacity funding for First Nations to lead Prevention*: First Nations need the capacity to lead prevention efforts for our children, youth, and families. We know our families best and must be empowered to support them.

- *Early Involvement of First Nations*: External service providers should involve the First Nation early, before harm leads to death. Contact the First Nations when our children and youth are struggling, and use our First Nations dispute resolution processes (such as the Anishinabek Nation Circle Process for Child and Youth Well-Being). The First Nation should be the first point of contact for support and must be provided with the necessary capacity funding to respond effectively.

- *Addressing the Opioid Epidemic and Addictions:* The opioid epidemic and addictions are major issues affecting many of our children, youth, and families. First Nations need the capacity to implement First Nations-led mental health and addiction services and supports.

- *Child Well-Being Supports On and Off-Reserve*: It is essential for First Nations to engage and support families both on and off-reserve, regardless of status. First Nations need the capacity to engage with off-reserve families and offer them prevention services, maintaining connections and, if desired, repatriating families back home. Identity is critical for children and youth, and First Nations need the resources to reconnect those who have become disconnected from their roots and identity.

- *Tracking the Entire Journey:* It is vital to monitor a child or youth's entire journey and ensure they receive the support needed to navigate various multi-sectoral services and systems both within and outside of the First Nations community, such as justice, corrections, education, and health. Special attention should be given to children and youth who end up outside of their family, such as in customary care or group homes, ensuring they maintain connections to their identity and First Nation culture. Devon's Principle and the right for every First Nations child or youth to return home must be implemented and First Nations must be provided funding to be able to implement Devon's Principle for our children and youth.

- *Mandatory Serious Occurrence Reports to First Nations:* It should be mandatory that First Nations immediately receive Serious Occurrence Reports from CASs and residential service providers. This notice should be legislated to ensure that First Nations can be notified and involved when serious incidents occur involving our children and youth, so we can help with support and planning to prevent future harm or death.

- *Parental Support:* There is a significant lack of supports for parents, which is crucial in preventing parent-child/youth conflicts and providing safe spaces and supports for youth, especially those facing challenges like being kicked out of their homes.

- *Education on Healthy Relationships & Life Skills:* Our children and youth need education and awareness on what constitutes healthy relationships, as well as life skills from both a traditional and non-traditional perspective. Our youth should gain life skills in both traditional and non-traditional areas, allowing them to navigate both worlds without experiencing culture shock.

- *Financial Planning & Mental Health & Addictions Supports for Compensation Payouts:* Large compensation payments can be harmful if families and communities are not prepared and do not have supports in place for financial literacy and planning, mental health and addictions supports, etc.. We need to ensure that these services and support are in place for our citizens.

- *Cultural Education for Care Providers:* It should be mandatory for all who work within the child welfare and residential care systems (ex. foster parents, residential staff, group home staff, etc.) and within the various ministries (ex. Ministry of Children, Community, and Social Services) to learn Anishinaabe teachings and culture.

- *Fostering Positivity through Positive Conversations and Collaborations & Positive Programming for Youth:* First Nations need innovative programming and messaging that promote positivity, self-confidence, and resilience among our youth. Sharing stories of strength and resilience is essential. We need to engage in holistic conversations and collaborations, including happiness retreats, positivity initiatives, and efforts to uplift and promote well-being in our communities. Youth need to see the positive contributions of our people, not just the negative aspects of our history. We should focus on stories of resilience and success, showing youth that they can live a good life and achieve great things.

- *Safe Spaces and Communities:* Creating safe spaces and communities for our children and youth is vital, including addressing the lack of proper housing and spaces for families. Safe spaces and supports for 2SLGBTQ+ children and youth is crucial.

- *Holistic Risk Assessment:* Risk assessments for First Nations children and youth should be conducted by those who genuinely care and understand our people, rather than by those disconnected from our communities.

- *Addressing Intergenerational Trauma:* Our families need supports in developing parenting skills and accessing family well-being services. The impacts of residential schools and intergenerational trauma are profound, and First Nations need adequate prevention funding for both on- and off-reserve citizens and families. Families need to feel supported and valued no matter where they may reside.

- *Community Engagement:* It is important to listen to families and understand their needs and the impacts they face. This will guide our efforts in prevention and support.

- *Addressing Multi-Sectoral Over-Representation:* First Nations are still over-represented in justice, corrections, child protection, and other systems. The government must listen to First Nations on what is needed to support well-being in our communities and provide the necessary capacity and supports. First Nations can identify service gaps and need the resources to address them.

- *Education on Systemic Racism and Discrimination:* Education and learning within the general public and among mainstream service providers are key to preventing and addressing systemic racism and discrimination.

- *Combat Lateral Violence and Bullying:* We need to build ways for our First Nations children and youth to value themselves and others, addressing lateral violence and bullying, which are often learned at home. Initiatives like a lateral kindness campaign are necessary.

- *Supporting Education in Community:* Our children and youth should be able to learn within their home communities without being forced to leave their families and the community. We need funding to support community-based education and curricula that promote Anishinaabe ways of learning.

- *Listening to Youth:* We need to ask our youth what makes them feel disconnected from their community, school, or friends, and strengthen their sense of belonging and pride.

- *Ensuring Basic Needs:* Families need proper housing, food, healthcare, and education. When these basic needs are unmet, it impacts the well-being of our families and communities. We need to ensure that our families have their basic needs met so that they can focus on positive well-being. This will help our children and youth to feel loved, accepted, and supported, giving them a strong sense of belonging.

- *Role Models for Well-Being:* Adults in our communities need to demonstrate well-being to set a positive example for our youth.

- *Challenging Prevention Programs:* We need to critically assess current prevention programs to ensure they are creative, effective and responsive to the needs of our people.

- *Leadership Opportunities for Youth:* Providing youth with leadership opportunities, such as youth councils and community programs, can foster a healthy mindset and sense of responsibility.

- *Accurate Data Tracking:* Accurate data tracking and monitoring by the OCC is key to preventing harm and death among First Nations children and youth.

- *Inclusion of First Nations Culture in Hospitals:* There is insufficient cultural sensitivity experienced in hospital settings and this negatively impacts the level of care provided to First Nations children and youth. This is particularly concerning for timing constraints and impacts on ceremonial practices. There needs to be OCC advocacy for better cultural sensitivity within health care settings as well as ensuring that First Nations cultural protocols and practices are respected and integrated into health care services.

- *Capacity for First Nations Youth Advocates***:** It was strongly recommended that funding be allocated to First Nations communities to have the capacity to develop Youth Advocate positions. These roles are essential for informing young individuals in care about their rights and for fostering connections to their First Nation community to help them build healthy identities and sense of belonging. The focus group noted that child protection agencies already receive funding for similar positions known as Child in Care Workers, underscoring the necessity for First Nations to have the capacity for the same sort of dedicated advocates.

- *Community-Centered Approach:* It takes a community to raise a child—this is the Anishinaabe way.

These preventionary measures are what we heard are essential for creating a safer, healthier future for our children and youth, grounded in respect for our Anishinaabe culture and identity.

During our engagements we heard from the expertise of our Anishinabek First Nations leadership, front line child well-being workers and community members that inclusivity, empathy, and a deep understanding of diverse worldviews are essential. The CYDR process must recognize the importance of community closeness, kinship structures, and ensuring that First Nations are able to practice our death ceremonies and protocols. When an investigation is underway, there should be a dedicated point of contact for the First Nation involved. It is crucial that we approach this work with a trauma-informed perspective, acknowledging the history of oppression that has shaped these experiences. We are people, not just numbers! The discussions that were held provide key recommendations on what actions and steps need to occur for the Office of Chief Coroner to make meaningful change towards transformation of the death investigations and the CYDR process towards creating a framework that honors our children, youth, families and communities.

Garden River Focus Group Summary

During the engagements that were held, it was suggested several times that there should be a focus group held within one of our Anishinabek First Nations to dialogue with child and family well-being and emergency services personnel about the topics discussed during the engagements. Garden River First Nation was selected as a focus group community due to the community's direct experience working with the Office of the Chief Coroner in CYDR protocol development and implementation for reviews of the tragic deaths of two of their youth. Chi-Miigwetch to Garden River First Nation for being open to sharing and dialoguing with us about your tragic losses and your experiences with the OCC and the CYDR process!

The focus group was held in Garden River First Nation territory on October 10th, 2024. The draft of this report and recommendations were reviewed with the focus group to identify any gaps and further insights. Participants were notably involved in child and family well-being services and community services. Chi-Miigwetch to Luanne Povey, Manager of Child and Family Services; Robin Hache, Restorative Justice Worker; Amanda Luther, Manager of Wellness Centre; Dawn Trepasso, Administrative Assistant; and Sammi Boisonneau/Sayers, Garden River Child Care Worker.

The feedback and expertise received from the focus group is summarized below:

Third Party Review and Governance

Many times where a child or youth death involves a CAS, the reviews investigating what had occurred are conducted by the CAS itself. Instead of this process in death reviews, it is important for there to be independent third-party reviews in child welfare cases to provide transparent, unbiased, and accountable reviews where the child or youth has had recent protection agency involvement.

Inclusion of First Nations Culture in Hospitals

Participants expressed concerns about the insufficient cultural sensitivity experienced in hospital settings and how this negatively impacts the level of care provided to First Nations children and youth. This was reported as particularly concerning timing constraints and impacts on ceremonial practices. The focus group advised that this be added to the Prevention Measures recommendations of this report to ensure that First Nations cultural protocols and practices are respected and integrated into health care services.

Reform of the *CYFSA* provisions regarding notification and consultation with First Nations

The focus group emphasized the need to strengthen sections 72 and 73 of the *Child, Youth and Family Services Act* (*CYFSA*) to ensure and reinforce the requirement for notice and consultation to First Nations communities regarding decisions about the care and placement of our children and youth.

Youth Advocates

It was strongly recommended that funding be allocated to First Nations communities to have the capacity to develop Youth Advocate positions. These roles are essential for informing young individuals in care about their rights and for fostering connections to their First Nation community to help them build healthy identities and sense of belonging. The focus group noted that child protection agencies already receive funding for similar positions known as Child in Care Workers, the necessity for First Nations to have the capacity for the same sort of dedicated advocates.

Repatriating Children and Youth Home for Burial

The focus group noted the importance for family services and child welfare services to be provided funding to support families in repatriating their child or youth loved one who has passed back to their home community for burial, particularly when the child or youth resides in a city away from their family and community (ex. they may have been placed in out of home care away from their parents or caregivers at the time of their death). If a family wishes, funding should be available to ensure the child or youth can be brought back to their family or home community for their final resting place. This support respects family wishes and upholds cultural practices.

The expertise and insights provided from Garden River First Nation were instrumental in providing feedback on our draft report and recommendations and in highlighting some additional recommendations need for prevention measures and repatriation needs. The focus group's insights underscored the importance of protocol development and the need for First Nations to be provided funding to have the capacity that is needed for the ongoing advocacy and collaboration with government on implementation of recommendations and reforms to support First Nations children, youth and families effectively.

Recommendations

Several recommendations emerged from the expertise and knowledge shared by our Anishinabek First Nation leadership, front line child well-being workers and community members during the engagements that were held on the topic of transformation of the Child and Youth Death Review process. The Office of the Chief Coroner must take actionable steps towards implementation of these recommendations to create meaningful transformation of the OCC's death investigations and Child and Youth Death Review processes and its work towards preventing the tragic deaths of our First Nation children and youth. Implementing these recommendations will enhance the cultural appropriateness, inclusivity, and effectiveness of the death investigations and CYDR process for our children, youth, families and communities are involved. The recommendations that emerged are outlined below and are not listed in any particular priority. All recommendations are a priority to be implemented to make positive and meaningful change. It is crucial for the OCC to step up to take actions to implement these recommendations through reform to its internal policies, directives and legislative review and amendments.

Recommendation 1
The Office of the Chief Coroner must recognize that our abinoojiinyag (children) are sacred gifts from the Creator. These are our Anishinaabe teachings about children and must be respected.

Recommendation 2
The Office of the Chief Coroner must take actionable steps towards implementing the recommendations from our Anishinabek First Nations. Actionable steps are the key to achieving true reconciliation.

Recommendation 3
It is recommended that the Office of the Chief Coroner embrace the Seven Grandfather Teachings of Zaagidwin (Love), Debwewin (Truth), Mnaadendmowin (Respect), Nbwaakaawin (Wisdom), Dbaadendiziwin (Humility), Gwekwaadziwin (Honesty), and Aakedhewin (Bravery) as guiding principles for all aspects of its work, including death investigations, the Child and Youth Death Review process and prevention efforts. Although these are Anishinaabe teachings, they can help to guide the work of the OCC in a good way that is respectful for all nationalities and cultures.

Recommendation 4
The Office of the Chief Coroner must respect Anishinaabe law and jurisdiction when it comes to our abinoojiinyag and communities. Our Anishinaabe ceremonies and customs are aspects of our Anishinaabe laws and the work of the Office of the Chief Coroner must take meaningful steps to ensure that our laws are respected in all of its work, including death investigations and Child and Youth Death Reviews.

Recommendation 5
The Office of the Chief Coroner must take immediate action towards ensuring implementation of all 75 recommendations provided by the Coroner's Inquest into the Death of Devon Freeman (Muska'abo).

Recommendation 6
The Office of the Chief Coroner must take immediate action towards implementing mandatory immediate notification to First Nations when an abinoojiinh (child) or youth from a First Nation occurs. As well, the OCC must ensure regular ongoing communications with the family and the First Nation. This must be a mandatory task for local coroners. It is recommended that this notification and ongoing communication be mandatory and reflected within the *Coroner's Act* and any other forms,policies,directives, legislation or regulations related to the work of the OCC.

Recommendation 7
The Office of the Chief Coroner must ensure that it respects the diversity of our First Nations and does not implement pan-Indigenous processes and approaches for its death investigations and Child and Youth Death Review processes.

Recommendation 8
The Office of the Chief Coroner must take steps to ensure that its death investigation and Child and Youth Death Review processes are accurately identifying and inclusive of First Nations youth regardless of where the child or youth may reside (ex. on or off reserve).

Recommendation 9
The Office of the Chief Coroner must take steps to ensure that its Child and Youth Death Review process is inclusive of youth and young adults up to the age of twenty-six years of age. This is in line with funding that is available to support First Nations youth and young adults who are transitioning from care in child welfare circumstances.

Recommendation 10
The Office of the Chief Coroner must take steps to ensure that its death investigation and Child and Youth Death Review process are accurately identifying and inclusive of First Nations children and youth regardless of whether the child or youth has been registered as a "status" Indian under the *Indian Act*.

Recommendation 11
The Office of the Chief Coroner must take immediate steps to reform the forms and databases that are used for death investigations and Child and Youth Death Reviews (ex. coroner's investigation forms, Child Fatality Case Summary Report forms, QuinC database system) to ensure that these forms and databases are accurately identifying First Nations children and youth and ensuring that First Nations are immediately notified about the death of their children or youth.

Recommendation 12
The Office of the Chief Coroner must implement a First Nations Liaison that would provide focus and attention that is needed for First Nations families and communities. The role and responsibilities of these liaisons would be to work directly with First Nations to help the First Nations (and First Nation families) to navigate death investigations and the Child Youth Death Review process, to help ensure ongoing dialogue and communications about investigations and reviews, and to work directly with First Nations on the develop and implementation of protocols surrounding death investigations and reviews. It is recommended that the OCC implement one or two First Nations Liaisons/Navigators within each of its regions who can work directly with the First Nations in that area.

Recommendation 13
The Office of the Chief Coroner must take active steps to review its recruitment efforts and improve and increase the recruitment of local coroner teams within each of its regions (especially needed are Indigenous local coroners), as well as other staff needed internally at the OCC to assist with the backlog that is faced in death investigations and reviews. It will be important for the OCC to implement recruitment for the First Nations Liaisons mentioned above in these recruitment efforts.

Recommendation 14
The Office of the Chief Coroner must reach out directly to each First Nation to strive to develop protocols to be implemented with each First Nation surrounding child and youth death investigations and Child and Youth Death Reviews. As well, the OCC must provide First Nations with capacity funding to be able to develop meaningful protocols and to meaningfully participate in any protocol implementation should a death occur. Funding should also be provided to First Nations and families when repatriating a child or youth loved one who has passed back to their home community for burial, particularly when the child or youth resides in a city away from their family and community (ex. the child or youth may be placed in out of home care and residing away from their parents or caregivers at the time of their death). If a family wishes, funding should be available to ensure the child or youth can be brought back to their family or home community for their final resting place. This support respects family wishes and upholds cultural practices.

Recommendation 15
The Office of the Chief Coroner must ensure that remote First Nations communities are provided additional capacity funding and considerations to meet their remoteness needs within any death investigations, Child and Youth Death Reviews and any protocol development and implementation activities that occur.

Recommendation 16
The Office of the Chief Coroner must take steps towards developing and implementing a more robust and trauma-informed cultural sensitivity training for all who work within the OCC. This training should be mandatory for all who work within the OCC and must involve land-based training directly with First Nations knowledge keepers. As well, the OCC should take steps to promote this cultural sensitivity training and trauma-informed approaches to be applied broadly within other mainstream systems and services sectors.

Recommendation 17
The Office of the Chief Coroner must advocate for the integration of trauma-informed cultural sensitivity training and education as a mandatory component of the elementary and secondary educational curriculum in Ontario.

Recommendation 18
The Office of the Chief Coroner must take steps to ensure that all staff and individuals working within the OCC receive mandatory cultural sensitivity training, including instruction on culturally sensitive and trauma-informed report writing approaches. Additionally, the OCC should ensure that all coroners are required to seek and include positive information about the deceased in their reports. This practice would honor the individual's life and identity, rather than relying solely on a clinical and impersonal approach to report writing.

Recommendation 19
To transform Child and Youth Death Reviews to better reflect complex and systemic factors that contribute to the harms and deaths of our First Nations children and youth, the Office of the Chief Coroner must take steps to broaden the scope of Child and Youth Death Reviews to directly include reviews of other sectors beyond child welfare such as justice, corrections, policing, health, education, etc.

Recommendation 20
The Office of the Chief Coroner must take steps to make it mandatory that the OCC is to seek to involve First Nations directly in any Child and Youth Death Review surrounding one of their children or youth, including the formulation of recommendations, and that all reports and recommendations that come from a CYDR are shared with the First Nation.

Recommendation 21
The Office of the Chief Coroner must develop a more robust process of providing follow up from Child and Youth Death Reviews to bring those who were involved together to report directly on steps taken to implement the recommendations from the reviews and any further follow up needed. Follow up should occur, at minimum, annually, and follow up circles could be implemented to align with Anishinaabe teachings and approaches. The OCC must also take concrete steps to improve its tracking and reporting on the implementation of recommendations from Child and Youth Death Reviews and inquests surrounding the death of First Nations children and youth to ensure that there are meaningful and lasting improvements to prevent these harms in the future.

Recommendation 22
The Office of the Chief Coroner must take steps to ensure that its annual reports are less technical, written in plain language and framed in a way that allows First Nations and others to easily use the content in the reports for public advocacy efforts needed to drive positive change and implementation. The annual reports must also include a summary of the general recommendations made across all Child and Youth Death Reviews in a given year and the OCC must implement a review every 5 years to assess and report what has been implemented from those recommendations and changes on death statistics.

Recommendation 23
Legislative reform of the *Coroner's Act* and the *Child, Youth and Family Services Act* are needed. First Nations voices must be prioritized in any legislative review of the *Coroner's Act* and recommendations for legislative change must be meaningfully integrated into the legislation. The OCC must use these recommendations from the Anishinabek Nation to inform any legislative change to the *Coroner's Act*. As well, and equally as important, the OCC must advocate for reform of the *Child, Youth and Family Services Act* to strengthen provisions surrounding notice and consultation to First Nation communities surrounding decisions about the care and placement of First Nations children and youth.

Recommendation 24
The Office of the Chief Coroner must ensure that First Nations have access to funding to support their advocacy efforts regarding Child and Youth Death Review (CYDR) transformation and legislative reviews of the Coroners Act and its regulations. Additionally, it is recommended that the OCC provide the Anishinabek Nation with resources to establish a hub to facilitate the sharing of information related to CYDRs among Anishinabek First Nations.

Recommendation 25
The Office of the Chief Coroner must work towards legislative change of the *Coroner's Act* to ensure that it directly recognizes and implements the *United Nations Declaration on the Rights of Indigenous Peoples* (*UNDRIP*) to ensure that the Indigenous rights contained within *UNDRIP* are upheld throughout all of the work of the OCC.

Recommendation 26
The Office of the Chief Coroner must take steps to collaborate with the Ministry of Children, Community and Social Services (MCCSS) and other relevant sectors to develop more efficient protocols and practices to ensure that those who work within the OCC (ex. local coroners) have more timely access to key records and information needed to conduct death investigations and reviews. A protocol between MCCSS and the OCC to allow the OCC to access CPIN, the provincial information management system used by Children's Aid Societies in Ontario, could be helpful to expediting the record sharing process for the OCC and CAS.

Recommendation 27
The Office of the Chief Coroner must take steps to create a more robust approach and system of data gathering and analysis with a view towards prevention of harms and deaths of our First Nations children and youth. The OCC must engage with the Anishinabek Nation to develop and implement a new and improved system of data gathering and governance.

Recommendation 28
The Office of the Chief Coroner must take steps to establish an internal Indigenous team or unit within the OCC that can help with implementing the above recommendations and needed changes. This dedicated Indigenous team would be instrumental to addressing the unique needs and concerns of Indigenous communities, ensuring that Indigenous perspectives and cultural practices are meaningfully integrated within the OCC's processes and operations.

Recommendation 29
Third Party Review & Governance – The Office of the Chief Coroner must take steps to require Child and Youth Death Reviews to be conducted by independent third parties. Many times where a child or youth death involves a CAS, the reviews of what had occurred are conducted by the CAS reviewing itself. This is problematic and it is important for there to be independent third-party reviews in child welfare cases to provide transparency, unbiased, and accountable reviews where the child or youth has had recent protection agency involvement.

Recommendation 30
The Office of the Chief Coroner must take steps to address the many prevention issues that are outlined within this report.

These recommendations are based on the expertise and guidance provided by our Anishinabek First Nations and are crucial to be implemented by the Office of the Chief Coroner if the transformation of its Child and Youth Death Reviews process is to be meaningful to our children, youth, families and nations.

Gordon "Chop" Waindubence
Knowledge Keeper

Next Steps - Implementation

It is evident that the discussions and engagements with our Anishinabek First Nations have laid a robust foundation to inform what is needed for positive transformation of the Child and Youth Death Review (CYDR) process. The collaborative efforts between the Ontario Office of the Chief Coroner (OCC) and the Anishinabek Nation have fostered the above recommendations that can result in a more culturally respectful, inclusive, and effective approach to handling the delicate matters of harms and deaths of our First Nations children and youth.

These recommendations are not just about reforming processes, but are also about honoring the spirits of our children and youth who have passed on.

Moving forward, the implementation of these changes will require continued commitment from the Office of the Chief Coroner and collaboration with the Anishinabek Nation and our First Nations to ensure that these recommendations become meaningful action that positively impacts the lives of the children and youth within our communities. Ongoing commitment from the Office of the Chief Coroner towards implementation of these recommendations will serve as a testament to the Office of the Chief Coroner's dedication to fostering the well-being and dignity of our children and youth and honouring the spirits of those who have made their journey home so young.

Chi-Miigwetch to the First Nation Participants and the Garden River First Nation Focus Group

Miigwech to all participants and to the Garden River First Nation Focus Group for taking the time to share your valuable feedback, suggestions, and for being present during this discussion on such a sad and difficult topic. Your contributions are deeply appreciated. The disproportionate statistics surrounding the overrepresentation of our Anishinabek Nation First Nations children and youth in care where our children account for more than 50% of those in care despite representing less than 8% of the child population highlight the critical importance of this work.

Chi-Miigwetch to Dr. Annelind Wakegijig

Miigwech Dr. Annelind Wakegijig for your valuable input and feedback. Your expertise and dedication to sharing with us from your direct perspectives and experiences as an Anishinaabe kwe and a local coroner is very greatly appreciated!

As we learnt, the language used by coroners and other service providers—like CAS, police, and hospitals—must be more compassionate, culturally informed and in alignment with our Anishinaabe laws and customs. The insensitivity often seen in reports and practices of local coroners and others involved in death investigations shows a lack of empathy for our families and of Anishinaabe culture. The work of local coroners and others investigating the deaths of our people should adopt a trauma-informed, culturally sensitive approach to honor those who have passed, especially children and youth, ensuring their stories are told with respect and dignity.

Chi-Miigwetch to our Social Development Department and Koganaawsawin

Miigwetch to our Social Development Department and Koganaawsawin for helping us to organize invites to child & family well being workers.

Chi-Miigwetch to Our Elders and Nation-Building Councils Who Attended

Chi Miigwech to the Elders, guest presenters and our various Nation-Building Councils who took the time to participate in our regional sessions and for sharing your invaluable knowledge. Your contributions have been deeply appreciated. Chi-Miigwetch especially to our Elders and Youth for conducting ceremonies, sharing your wisdom, and guiding us. Your presence continues to inspire and strengthen us as we work together toward meaningful change for our Nation.

Chi-Miigwetch to Turtle Concepts and Sellebration Productions

Miigwech to our facilitators, Turtle Concepts, and to our tech crew, Sellebration Productions, for your hard work and dedication. Your smooth coordination and support were essential to the success of these engagement sessions, and we deeply appreciate your efforts in helping everything run seamlessly.

A special Chi-Miigwech to Turtle Concepts for the inspiring facilitator techniques that encouraged us all to see the opportunities ahead, to follow our Seven Grandfather Teachings and to seek out the positive, even on such a difficult and saddening topic.

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