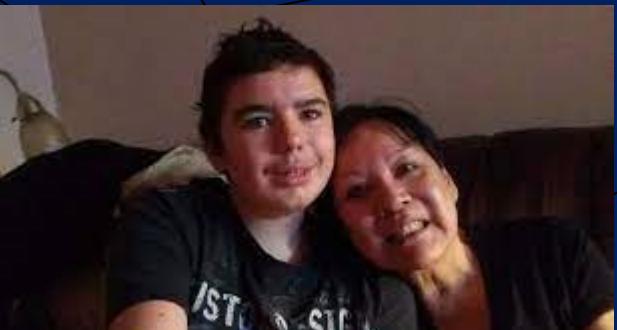


Lessons Learned from the Devon Freeman Inquest

Sarah Clarke



Devon Freeman (Muska'abo)

In June 2018, Shannon Crate received a copy of Devon's death certificate in the mail from Devon's grandmother, Pamela Freeman.

Road to the Inquest

- ▶ Disclosure
- ▶ Options
- ▶ Support
- ▶ Process
- ▶ Safe with Intervention
- ▶ COVID

His early life

Devon Freeman

Devon was connected to the Chippewas of Georgina Island through his mother

His grandmother, Pamela Freeman, is a survivor of the Indian Day School system

Devon's mother cared for Devon and his sisters. His father was abusive.

Children's Aid was involved early on in Devon's life in relation to the abuse inflicted by Devon's father

Eventually Devon and his sisters went to live with his grandmother, Pamela

When Devon was six years old, Devon's mother died suddenly. This had a profound impact on him

After Devon's mother passed away, Pamela did everything she could to get Devon the supports she knew he needed

Devon struggled in school

Pamela's Efforts to Support Devon

Complex trauma services through child and adolescent services

Banyan Community Services

Pediatrician diagnosis and medication supervision

Big Brother Program

Child psychiatrist

Aboriginal Health Centre

Lynwood Charlton Centre Day Treatment Program

CONTACT Hamilton

Child and Youth Health Outpatient Program

Intensive Child and Family Services Program

Woodview Delta Program

Devon Goes to Jeb's Place

- ▶ Devon accessed a community bed at Jeb's Place, going home on the weekends
- ▶ Devon disclosed that he felt like hurting himself - he was discharged from hospital each time this occurred
- ▶ Devon vocalized wanting to end his own life throughout his time at Jeb's Place but did well in the program and Pamela believed it was the right place
- ▶ Devon started attending the Hamilton Regional Indian Centre and began individual sessions with a Wasa-Nabin worker
- ▶ Devon transitioned from Woodview Delta back into the mainstream education system. This was a challenge

Children's Aid Involvement

- ▶ Referral received regarding Devon's abusive behaviour towards Pamela
- ▶ Jeb's Place indicated that Devon could not remain in the program long term as they did not have the capacity to support long term placements
- ▶ Pamela was concerned about him coming home
- ▶ Prior to leaving Jeb's Place, Devon reported that he had attempted to hang himself. This was reported to the Society but not to Pamela or the First Nation
- ▶ The Society commenced a protection application for crown wardship in order to offer Devon a residential placement
- ▶ Devon was placed in a foster home that eventually broke down
- ▶ Devon continued to see his psychiatrist but medication reviews

Lynwood Charlton

Children's Mental Health Facility

Lynwood was not informed of a history of suicidal ideation or any prior suicide attempts

Devon did make suicidal comments

Section 23 classroom

In April 2017, Devon started to leave without permission

Devon started karate

In May 2017, Devon reported that he attempted to hang himself from a tree

Pamela was involved in planning or safety planning

In June 2017, Devon became a Crown ward

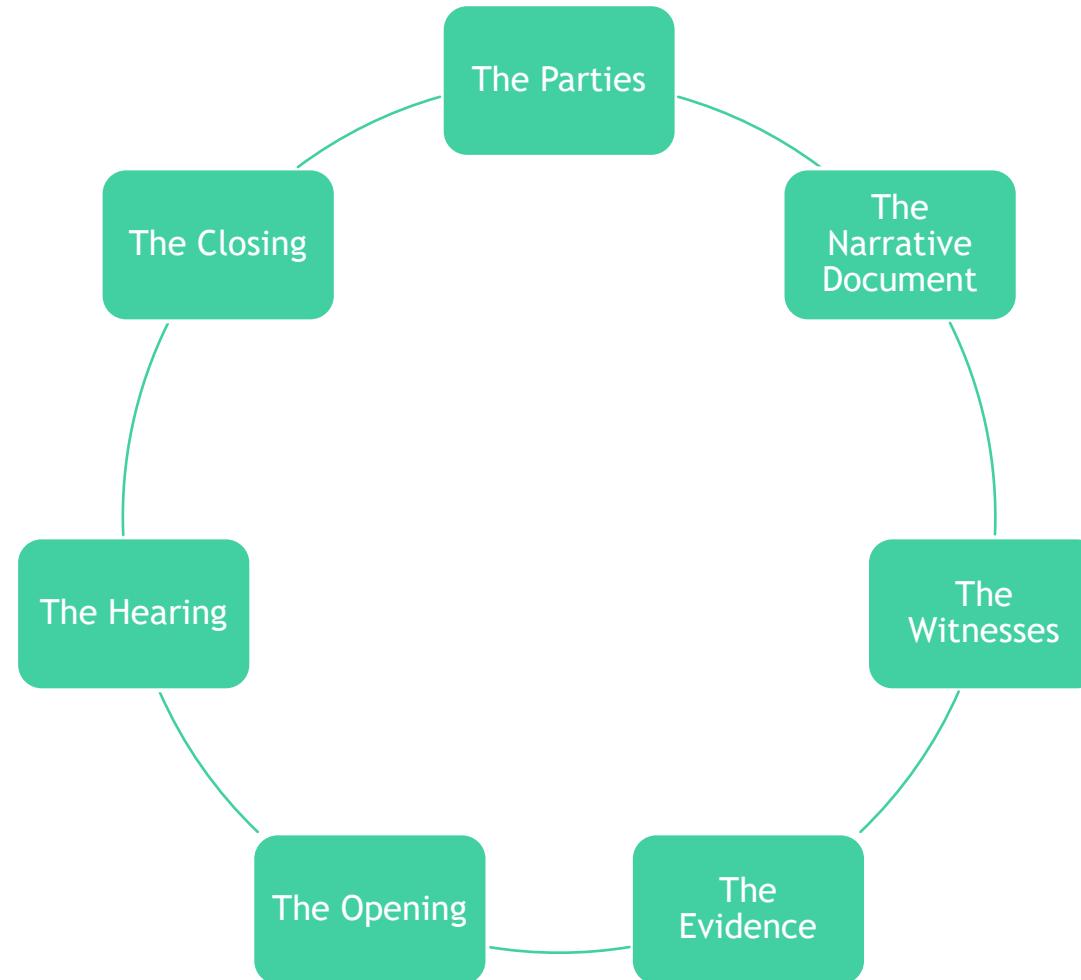
September 30 memorial for Devon's mom

Devon's Final Days

The Timeline

- ▶ October 6, 2017: Devon has an argument with a peer in the house: the peer taunts Devon about his mother
- ▶ Devon was very upset. He defriended with staff
- ▶ October 7, 2017: Devon left for the last time
- ▶ Missing Persons Report filed
- ▶ Society had concerns that the volume of Devon's AWOLs clouded the severity of his current disappearance
- ▶ Society did not tell the First Nation that Devon was missing
- ▶ November 27, 2017: media release issued
- ▶ April 12, 2018: Devon's body is discovered
- ▶ October 30, 2018: Society held a memorial for Devon

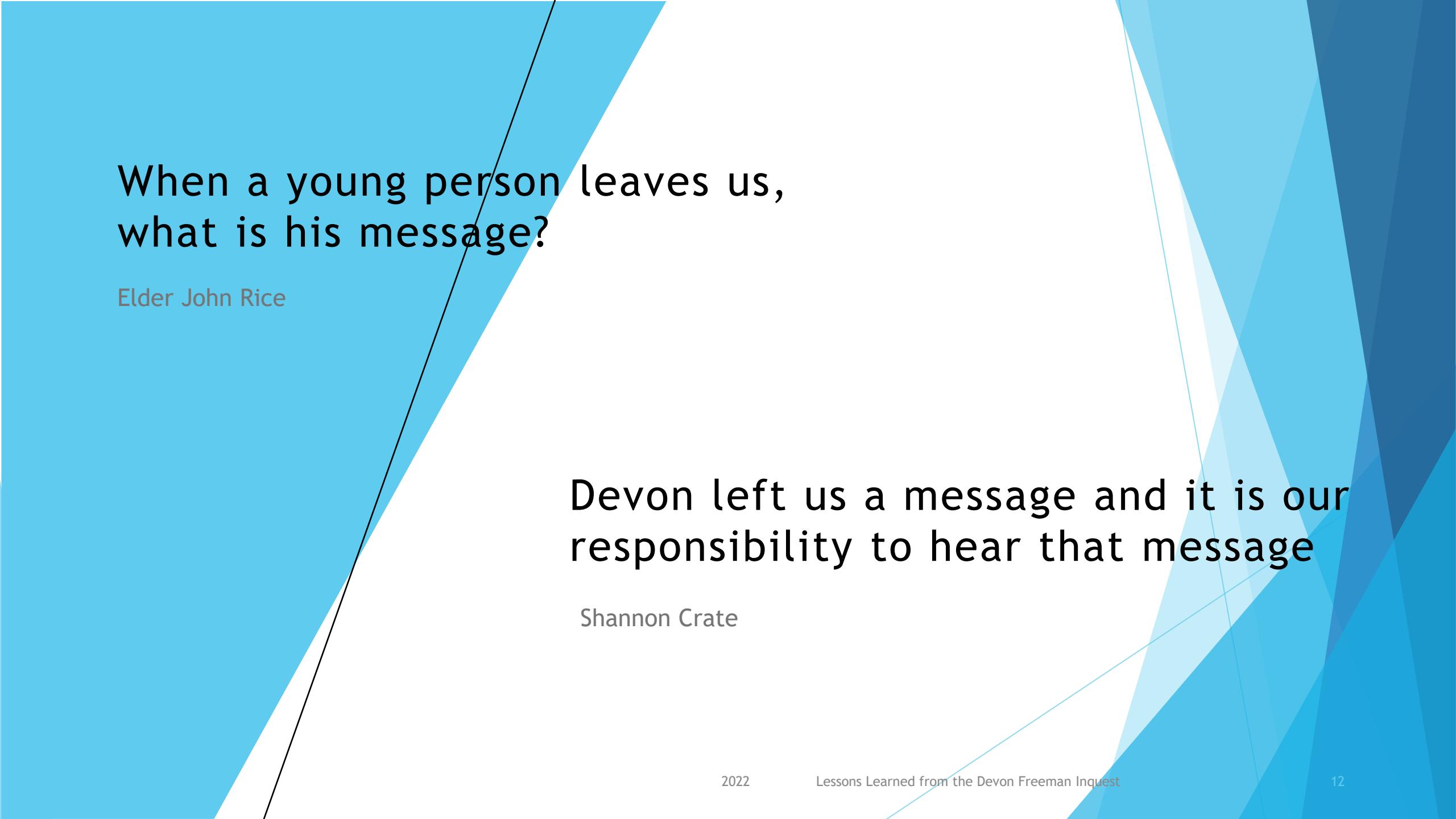
The Inquest Process



What did we Learn?

Lessons Learned from the Devon Freeman Inquest





When a young person leaves us,
what is his message?

Elder John Rice

Devon left us a message and it is our
responsibility to hear that message

Shannon Crate

Lessons from Devon's Life and Death

BELONGING	FAMILY	COMMUNICATION	CULTURE	CONSULTATION
Devon did not know the history of his family	Pamela was not involved in his planning or care	The helping agencies were not talking to each other of the First Nation	Devon was searching for culture	The First Nation was not consulted

TO ALL INSTITUTIONAL PARTIES:

59. That the MCCSS and all institutional parties to this inquest work together in a collaborative manner towards ensuring that First Nations children have a right to return to their home communities when receiving services under the CYFSA. This should be adopted and developed as Devon's Principle.

Recommendation: The Right to Return

TO THE INSTITUTIONAL PARTIES (CHIPPEWAS OF GEORGINA ISLAND, THE SOCIETY, LYNWOOD CHARLTON CENTRE (“LYNWOOD”), MINISTRY OF CHILDREN, COMMUNITY AND SOCIAL SERVICES (“MCCSS”) AND HAMILTON POLICE SERVICES (“HPS”)):

1. Led by the Chippewas of Georgina Island First Nation, support the development and delivery of a case study training module for children’s aid societies and residential service providers regarding the lessons arising from Devon Freeman’s life and death and incorporate information from the Narrative document (with the exclusion of personal identifiers or information that may identify individuals or otherwise assign blame). Any requests to obtain and use video or other recordings from the inquest shall be made to the Office of the Chief Coroner for their consideration.

Recommendation: Keep Learning

**TO THE MINISTRY OF CHILDREN, COMMUNITY AND SOCIAL SERVICES AND THE
MINISTRY OF HEALTH:**

62. To improve outcomes for First Nations children and youth, empower and seek to fund bands and First Nation communities and affiliated stakeholders (such as the Association of Native Child and Family Services Agencies of Ontario) to collect data and analyze data to determine whether, and to what extent, child welfare interventions and services are improving outcomes for children and youth.

**Recommendation: Understand
the Outcomes**

TO THE CHILDREN'S AID SOCIETY OF HAMILTON

43. To support ongoing consultation, communication, and transparency between the Society and the bands and First Nations communities of the children and youth it serves, the Society shall reach out to those bands and First Nation communities and offer to develop a communication protocol and offer to initiate quarterly reviews regarding all children receiving services from the Society.

Recommendation: Engage in Consultation

TO THE HAMILTON POLICE SERVICES

14. Review and revise the risk assessment process and policies that govern whether a missing person is classified as “Level 1” or “Level 2”, as well as whether an urgent search is required. The revised risk assessment factors, as well as search urgency factors, should be evidenced-based and clearly defined. In determining whether an MPI is classified as a “Level 1”, the revised process should require gathering additional information about the missing person, including but not limited to:

- a. any history of suicidal behaviours (ideations or attempts);
- b. whether the person is in an out-of-home placement at a mental health facility for children and youth; and,
- c. whether the missing person is an Indigenous youth.

Recommendation: Missing Persons



2022

What happens
now?

Implementation

The Parties have six (6) months to report back to the Coroner's Office regarding the implementation of the recommendations

Advocacy

Refer to the recommendations as often as you can to anyone who will listen. Legislative change will be required to implement the recommendations.

Litigation

Child protection litigators can refer to recommendations in child protection proceedings to start getting traction to implement.



Questions & Thank you!

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