Office of the Chief Coroner
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Bureau du Coroner en Chef
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June 12, 2012

Ms. Rose Caterini
City Clerk, City of Hamilton
City Hall, 71 Main Street West
1st Floor
Hamilton ON L8P 4Y5

Dear Ms. Caterini:

Re: Inquest into the death of Christopher Skinner.
Deceased June 6, 2010. Our file number Q2012-03.

Please find enclosed, a copy of the verdict and recommendations of the coroner's jury and the coroner's verdict explanation from the inquest into the death of Christopher Skinner. Your organization has been identified as one that may be in a position to implement recommendation 11; and I would appreciate your response to this recommendation as well as any others that you feel your organization may be in a position to implement.

Also attached, for your information is a list of the recipients that have been asked to respond to the recommendations.

For assistance in the preparation of your response, please refer to the attached chart. You are requested to complete the chart by self-evaluating your response according to the coding provided. Please be advised that your response and the attached chart will be considered public documents and may be released to interested parties upon request.

If you feel the recommendation has been assigned incorrectly, your suggestions as to where to direct the recommendation would be greatly appreciated.

The Office of the Chief Coroner will be preparing a report on 2012 inquests. The analysis of inquest responses may be included in that report. To facilitate this process please submit your response by February 2013.

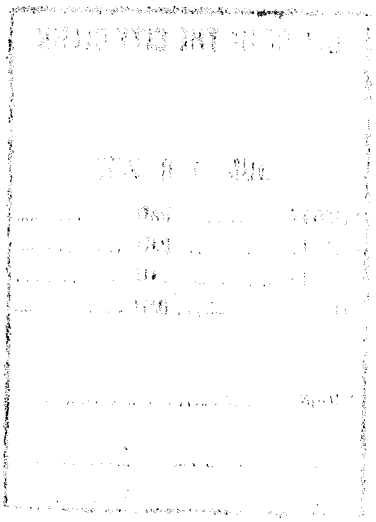
Please direct your response to:

A. E. Lauwers, MD, CCFP, FCFP
Deputy Chief Coroner – Inquests for Ontario
Office of the Chief Coroner
26 Grenville Street
Toronto ON M7A 2G9

Yours truly,

Andrew L. McCallum, MD, FRCPC
Chief Coroner for Ontario

ALM:pc
Encls.



Response Code	Response Legend
1	Recommendation *has* been implemented
1A	Recommendation *will* be implemented
1B	Alternate recommendation *has been* implemented
2	Under consideration
3	Unresolved issues
4	Rejected
4A	Rejected due to flaws
4B	Rejected due to lack of resources
5	Not applicable to agency assigned
6	No response
7	Unable to evaluate
8	Content or intent of recommendation is already in place

File – Q2012-03
For implementation:

Mr. Murray Segal
Deputy Attorney General
McMurtry-Scott Building
11th Floor, 720 Bay Street
Toronto ON M7A 2S9
(Recommendations – 1 to 3)

Ms. Carol Layton
Deputy Minister
Ministry of Transportation
3rd Floor, Ferguson Block
77 Wellesley Street West
Toronto ON M7A 1Z8
(Recommendation – 3)

Mr. George Zegarac
Deputy Minister, Ministry of Education
22nd Floor, Mowat Block
900 Bay Street
Toronto ON M7A 1L2
(Recommendations – 6 to 8)

Mr. Saad Rafi
Deputy Minister
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 1R3
(Recommendations – 9 and 10)

Mr. Alexander Bezzina
Deputy Minister
Ministry of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto ON M5S 2S3
(Recommendation – 16)

File – Q2012-03
For implementation:

Mr. Jean Major
Chief Executive Officer
Alcohol and Gaming Commission of Ontario
2nd Floor, 90 Sheppard Avenue East
Toronto ON M2N OA4
(Recommendations – 1 to 5)

Mr. Bob Peter
Chief Executive Officer
Liquor Control Board of Ontario
1100-1 Yonge Street
Toronto ON M5E 1E5
(Recommendations – 4 and 5)

Ms. Rose Caterini
City Clerk
City of Hamilton
City Hall, 71 Main Street West
1st Floor
Hamilton ON L8P 4Y5
(Recommendation – 11)

Mr. John Malloy
Director of Education
Hamilton-Wentworth District School Board
Education Centre
100 Main Street West, P.O. Box 2558
Hamilton ON L8N 3L1
(Recommendations – 12 and 13)

Ms. Patricia Amos
Director of Education
Hamilton-Wentworth Catholic District School Board
90 Mulberry Street, P.O. Box 2012
Hamilton ON L8N 3R9
(Recommendations – 12 and 13)

File – Q2012-03
For implementation:

Ms. Gyslaine Hunter-Perreault
Director of Education
Conseil Scolaire Viamonde
116 Cornelius Parkway
Toronto ON M6L 2K5
(Recommendations – 12 and 13)

Mr. Rejean Sirois
Director of Education
Conseil Scolaire de District Catholique Centre Sud
110 Avenue Drewry
Toronto ON M2M 1C8
(Recommendations – 12 and 13)

Chief of Police Glenn De Caire
Hamilton Police Service
155 King William Street
P.O. Box 1060, LCD1,
Hamilton ON L8N 4C1
(Recommendations – 12 and 13)

Executive Director
Alternatives For Youth
110-100 Main Street East
Hamilton ON L8N 3W4
(Recommendations – 14 and 15)

Executive Director
Reach Out Centre For Kids
471 Pearl Street
Burlington ON L7R 4M4
(Recommendations – 14 and 15)

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de Stoney Creek, Ontario
_____ of / de Dundas, Ontario
_____ of / de Hamilton, Ontario
_____ of / de Hamilton, Ontario
_____ of / de Waterdown, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
SKINNER	Christopher

aged / à l'âge de 17 years held at / tenue à 45 Main Street E, Hamilton, Ontario

from the / du 13th February to the / au 24th February 20 12

By / Par Dr. / Dr Jack Stanborough Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Christopher Skinner

Date and Time of Death / Date et heure du décès
June 6, 2010 11:13am

Place of Death / Lieu du décès
58 Chudleigh St., Waterdown, Ontario

Cause of Death / Cause du décès
Acute Ethanol Poisoning

By what means / Circonstances du décès
Accidental

The verdict was received on the / Ce verdict a été reçu le 24th (Day / Jour) day of February (Month / Mois) 20 12

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. Jack Stanborough	2012.02.24.

Coroner's Signature / Signature du coroner

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes : (voir page 2)

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Inquest into the death of:
Enquête sur le décès de :

Christopher Skinner

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

Recommendation to the Ministry of the Attorney General and the Alcohol and Gaming Commission of Ontario

1) To decrease the opportunity for underage drinking (persons under nineteen) and to deter individuals from allowing underage drinking in their homes, amend the Liquor Licence Act to include an offence that prohibits a homeowner or lessee from allowing a minor to consume liquor, unless it is given to the minor by his or her parent or guardian in a residence for consumption in the residence where the parent or guardian is present.

2) That the fine for supplying alcohol to an underage person be increased to the following:
a) a minimum fine of $500 for a first offence
b) a minimum fine of $1000 for a second offence
c) that incarceration for a period of up to 90 days be available for a third or subsequent offence.

Recommendation to the Ministry of the Attorney General, the Alcohol and Gaming Commission of Ontario, and the Ministry of Transportation

3) To deter young people from engaging in underage drinking and to increase opportunities for the adoption of behaviours that reduce underage drinking, amend the Liquor Licence Act for persons under the age of 19 years convicted of offences pursuant to subsections 30 (8) and 30 (12) to:
a) impose a minimum fine of $100 and participation in a recognized diversion programme for education purposes (mandatory for youth and parent/guardian) on first offence
b) issue a summons (appear in court), impose a fine, and suspend the driver's licence (or delay the eligibility to gain a driver's licence) of a person under 19 years of age on a second or subsequent offence

Recommendations to the Alcohol and Gaming Commission of Ontario and Liquor Control Board of Ontario:

4) To decrease the sale of alcohol to persons under 19 years of age and to reduce the use of false identification by persons under 19 years of age, issue best practice guidelines to retailers to ensure proper ongoing training of employees and to increase compliance with age identification verification processes; and
5) To enhance opportunities and methods employed to detect false identification, review existing practices for validating age identification and explore feasibility of enhanced measures to confirm age identification.

Recommendations to the Ministry of Education:

6) To ensure consistent mandatory education of elementary and secondary students, revise the current curriculum to ensure that students are provided with regular, appropriate, accurate, up-to-date information relating to:
a) the health and social issues associated with alcohol abuse in teens;
b) the legal consequences of underage drinking;
c) the resources available in the community to address issues relating to underage drinking;
d) current misconceptions relating to "accepted" drinking practices;
e) signs and symptoms of alcohol poisoning (e.g. passing out is not sleeping, when to call 911)

7) To ensure that school boards are employing evidence-based strategies and best practices relating to the prevention of underage drinking, establish and issue best practice guidelines to school boards relating to school-based youth substance abuse prevention as issued by the Canadian Centre on Substance Abuse, Building on our Strengths: Canadian Standards for School-based Youth Substance Abuse Prevention; the Ministry of Health Promotion, May 2010, School Health Guidance Document; and the Ontario Physical Health Association.

8) An annual alcohol awareness programme be developed for students (and respective parents/guardians) in Grades 7 through 12, where information is provided to assess a child's risk with regard to underage drinking.

Recommendations to the Ministry of Health and Long Term Care:

9) To ensure continuity of care of young persons who are engaging in dangerous drinking behaviours, expedite the development of a province-wide secure electronic health records system to ensure timely transmission of emergency records to identified family and/or attending physicians; and

10) Given the current wait lists for family physicians and the number of persons in Ontario who do not have a family physician, issue a directive to emergency health care practitioners to provide information relating to community resources available to families seeking advice relating to adolescent substance abuse issues.

Recommendation to the City of Hamilton Public Health Service (in consultation with Local School Boards, the Hamilton Police Service, and relevant drug and alcohol agencies for youth):

11) To increase public awareness and to engage the community in evidence-based alcohol prevention strategies, develop a local media campaign that:

a) highlights the prevalence of underage binge drinking in the community;

b) highlights the health and social issues associated with alcohol abuse in teens;

c) highlights the subject of this inquest through a video documentary interviewing parties involved;

d) highlights the legal consequences of underage drinking including allowing minors to drink in your home;

e) highlights the resources available in the community to address issues relating to underage drinking;

f) highlights current misconceptions relating to "accepted" drinking practices;

g) highlights signs and symptoms of alcohol poisoning (e.g. passing out does not equal sleeping, when to call 911); and

h) makes available statistics regarding youth's alcohol misuse and how alcohol's misuse can lead to risky behaviours, even death utilizing the schools' websites as one means of communication

Recommendation to the Hamilton-Wentworth District School Board, the Hamilton Catholic School Board, Le Conseil scolaire Viamonde and Le Conseil scolaire de district catholique Centre-Sud and the Hamilton Police Service:

12) To ensure enforcement of the Liquor Licence Act and to increase opportunities for the adoption of behaviours that reduce underage drinking, review and consider changes to the current Hamilton Police/School Board Protocol in relation to the notification of police in all instances involving supply of alcohol to a minor and/or all instances of possession of alcohol and/or all instances of intoxication by a minor.

13) To promote a network for parents of youth to discuss risky behaviours including underage drinking

Recommendation to Alternatives for Youth and ROCK (Reach Out Centre for Kids) and other provincial relevant drug and alcohol agencies for youth:

14) To ensure that family physicians are aware of health issues experienced by their patients and to increase opportunities for the treatment and care of young people who are engaging in dangerous drinking behaviour, at intake stage, obtain complete information relating to a young person's family physician and, if consent is provided, notify the family physician of the young person's reasons for consultation and the outcome of the consultation.

15) To implement appropriate follow-up procedures to ensure the best possible outcome for the client post-consultation

Recommendation to the Ministry of Child and Youth Services:

16) In an effort to protect children, it is recommended that the age of protection for children be raised to the age of 18 under the Child and Family Services Act.

Verdict Explanation
DATE ISSUED: JUNE 2, 2012
Christopher Skinner
Feb. 13 – 24, 2012
John Sopinka Courthouse
45 Main Street East
Hamilton

Opening comment:

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

Participants:

Counsel to the Coroner:
Ms. Karen Shea
Crown Counsel - High Risk Offenders
John Sopinka Court House
Central West Region
45 Main Street East
Hamilton, ON, L8N 2B7
(905) 645-5275

Investigating Officer:
Sergeant Paul Johnston, #664
Investigative Services Branch
Homicide Unit
Hamilton Police Service
155 King William Street
Box 1060, LCD 1
Hamilton, ON, L8N 4C1
Telephone #

Coroner's Constable:	Detective Mary Sullivan Coroner's Office Investigative Services Division Hamilton Police Service 155 King William Street Box 1060, LCD 1 Hamilton, ON, L8N 4C1 (905) 546-3850
Court Reporter:	Ms. Vicki Scott Cindy Jones Verbatim 76 Barons Court London, ON, N6C 5J3 (519) 690-2226 E-mail: vgscott@yahoo.com
Parties with Standing:	**Represented by:**
Skinner Family	Counsel Mr. Neil R. Jones Mackesy Smye LLP Barristers & Solicitors 2 Haymarket Street Hamilton, ON L8N 1G7 (905) 525-2341 x115
Baron Family	Counsel Mr. Kirk R. McPherson Counsel Mr. Joel Chrolavicius Sullivan Festeryga LLP Barristers & Solicitors One James Street South, 11th Floor Hamilton, ON L8P 4R5 (905) 528-7963 x129
Hamilton Police Service	Counsel Mr. Marco Visentini 155 King William Street Box 1060, LCD 1 Hamilton, ON L8N 4C1 (905) 546-4925

The Rock Organization For Youth	Counsel Mr. Paul Stunt O'Connor MacLeod Hanna LLP Barristers & Solicitors 700 Kerr Street Oakville, ON L6K 3W5 (905) 842-8030
Halton Healthcare	Counsel Ms. Anna L. Marrison Borden Ladner Gervais LLP Barristers & Solicitors Scotia Plaza, 40 King Street West Toronto, ON M5H 3Y4 (416) 367-6674
Dr. Kevin Byron	Counsel Mr. Brian Whitwham McCarthy Tetrault LLP Barristers & Solicitors Box 48, Suite 5300 Toronto Dominion Bank Tower Toronto, ON M5K 1E6

Summary of the Circumstances of the Death:

Christopher Skinner was seventeen years old and a student at Waterdown High School at the time of his death. He was bright, with high academic grades and was very socialwith many friends. He was regarded as a gifted musician, being the lead singer in a rock band, and was ambitious; in the summer he died, he had plans to work three, and possibly four, jobs.

Christopher Skinner was also known to "party hard" and binge drink with friends on a regular basis. His parents had addressed this matter a number of times, and had forced Christopher to write an essay on the effects of alcohol as punishment for one such binge drinking episode. In the year prior to his death, he had presented to the emergency department significantly compromised by a combination of drugs and alcohol. As a result of this hospital encounter, his mother took him to the 'ROCK' organization for youth to seek counselling. He only attended once with his mother, believing that no further counselling was required.

On the night of his death, Christopher attended a small house party where he and a small group of male friends drank and played drinking games in the backyard. Later that evening, he went to a residence where friends had gathered. The inquest heard that drinking games continued and marijuana was smoked in the garage by some of the attendees.

At around 03:00, Christopher was witnessed by a number of individuals to take a large quantity of "Newfie Screech" in a single ingestion in the kitchen. By this time, he was

behaving as if he was significantly intoxicated and shortly thereafter, he 'passed out' in the living room. Most of the attendees had left by this point, but at least three individuals, including a parent, proceeded to write graffiti on Christopher's body with magic markers. Christopher's legs were also bound with duct tape and a pile of CD cases was piled on his head. He apparently did not respond, so a friend's younger brother slept on the couch beside him for the remainder of the night.

The next morning, Christopher Skinner was found to be cold and unresponsive. EMS was called and he was pronounced dead at the residence. The police and the responding coroner found photographs on an electronic device at the residence which showed other teenagers who appeared unconscious with graffiti written on their bodies. This was suggestive of repetitious behaviour by the teenagers and possibly the parents at the residence.

An autopsy was carried out at the Hamilton Forensic Unit. No traumatic injuries were identified and the cause of the death was determined through toxicological analysis to be due to alcohol toxicity.

The salient issue that arose from this death was the issue of teenage drinking and the impact on both morbidity and mortality. The death was reviewed in a multi-disciplinary case conference and the attendees were of the opinion that this death, reviewed through a discretionary inquest, would meet the Coroners' mandate of public education with the intent of preventing similar deaths in similar situations.

The jury sat for ten days hearing from thirty-one witnesses, reviewed forty-six exhibits and deliberated for six hours in reaching the verdict.

Verdict:

Name of Deceased:	**Christopher Skinner**
Date and time of Death:	**June 6, 2010 @ 11:13 a.m.**
Place of Death:	**58 Chudleigh Street, Waterdown, Ontario**
Cause of Death:	**Acute Alcohol Poisoning**
By What Means:	**Accident**

Recommendations:

To the Ministry of the Attorney General and the Alcohol and Gaming Commission of Ontario:

1. **To decrease the opportunity for underage drinking (persons under nineteen) and to deter individuals from allowing underage drinking in their homes, amend the *Liquor License Act* to include an offence that prohibits a homeowner or lessee from allowing a minor to consume liquor, unless it is given to the minor by his or her parent or guardian in a residence for consumption in the residence where the parent or guardian is present.**

Coroner's Comments: *The inquest heard that, at present, the law in Ontario prohibits adults from providing alcohol to underage children (who are not their children). However, the present legislation does not prohibit adults from allowing persons under the age of 19 (who are not their children) to consume alcohol in their residence. When laws from other provinces were reviewed, it was determined that several provinces prohibited adults from supplying alcohol to underage persons who were not their children. In addition, in some provinces, the law went so far as to prohibit a homeowner from allowing excessive drinking in the residence.*

2. **That the fine for supplying alcohol to an underage person be increased to the following:**
    a. **A minimum fine of $500 for a first offence.**
    b. **A minimum fine of $1,000 for a second offence.**
    c. **That incarceration for a period of up to 90 days be available for a third or subsequent offence.**

Coroner's Comments: *Several witnesses testified that the current fines for supplying alcohol to a minor were considered insignificant and not a deterrent. By imposing more significant penalties, more individuals would be deterred from supplying alcohol to underage persons.*

To the Ministry of the Attorney General, the Alcohol and Gaming Commission of Ontario, and the Ministry of Transportation:

3. **To deter young people from engaging in underage drinking and to increase opportunities for the adoption of behaviours that reduce underage drinking, amend the *Liquor License Act* for persons under the age of 19 years convicted of offences pursuant to subsections 30 (8) and 30 (12) to:**
    a. **Impose a minimum fine of $100 and participation in a recognized diversion program for education purposes (Mandatory for youth and parent/guardian) on first offence.**

b. **Issue a summons (appear in court), impose a fine, and suspend the driver's license (or delay the eligibility to gain a driver's license) of a person under 19 years of age on a second or subsequent offence.**

Coroner's Comments: *Several witnesses testified about the apparent benefits of diversion programs for underage individuals and that the current penalties for underage drinking do not have the desired deterrent effect. A number of the young witnesses were of the opinion that a 'significant' loss, such as the loss of the privilege to drive, may act as an appropriate deterrent to underage drinking, similar to the effect previously seen in society with 'drinking and driving'. At present, diversion programs are not available for any individuals who are charged with offences under the Provincial Offences Act. In addition, diversion for persons under the age of 18 is only available in those instances where the offence charged is pursuant to the Criminal Code or the Controlled Drugs and Substances Act.*

To the Alcohol and Gaming Commission of Ontario and Liquor Control Board of Ontario:

4. **To decrease the sale of alcohol to persons under 19 years of age and to reduce the use of false identification by persons under 19 years of age, issue best practice guidelines to retailers to ensure proper ongoing training of employees and to increase compliance with age identification verification processes; and**

5. **To enhance opportunities and methods employed to detect false identification, review existing practices for validating age identification and explore feasibility of enhanced measures to confirm age identification.**

Coroner's Comments: *The inquest heard from the young witnesses who attended the party that the use of false identification was 'routine' amongst the youth and that there was very little to no impediment to obtaining alcohol using false identification.*

To the Ministry of Education:

6. **To ensure consistent mandatory education of elementary and secondary students, revise the current curriculum to ensure that students are provided with regular, appropriate, accurate, up-to-date information relating to:**
   a) **the health and social issues associated with alcohol abuse in teens;**
   b) **the legal consequences of underage drinking;**
   c) **the resources available in the community to address issues relating to underage drinking;**
   d) **current misconceptions relating to "accepted" drinking practices;**

e) **signs and symptoms of alcohol poisoning (e.g. passing out is not 'sleeping', when to call 911).**

Coroner's Comments: *The inquest heard that education is the cornerstone to understanding and appreciating the risks associated with binge drinking. At present, the current curriculum has mandatory instruction at Grade 9 level in health and physical education, but after that, education on this issue will vary depending on the courses selected by the student. The only mandatory subject through to Grade 12 is English. Testimony indicated that the school setting is an appropriate venue to "deliver the message" at the appropriate time and on a consistent basis.*

7. **To ensure that school boards are employing evidence-based strategies and best practices relating to the prevention of underage drinking, establish and issue best practice guidelines to school boards relating to school-based youth substance abuse prevention as issued by the Canadian Centre on Substance Abuse, *Building on our Strengths: Canadian Standards for School-based Youth Substance Abuse Prevention*; the Ministry of Health Promotion, *May 2010, School Guidance Document*; and the Ontario Physical Health Association.**

Coroner's Comments: *Efforts are currently underway to issue evidence-based, best practice guidelines within the education system with a view to recognizing and preventing youth substance abuse. Many of the witnesses from the local school boards were not familiar with these guidelines and, upon being made aware of them, felt that they would be useful tools for addressing youth substance abuse.*

8. **An annual alcohol awareness program be developed for students (and respective parents/guardians) in Grades 7 through 12, where information is provided to assess a child's risk with regard to underage drinking.**

Coroner's Comments: *Evidence presented suggests that experimentation with drinking starts as early as elementary school and that the most effective interveners to assess and deal with the problem are the parents.*

To the Ministry of Health and Long Term Care:

9. **To ensure continuity of care of young persons who are engaging in dangerous drinking behaviours, expedite the development of a province-wide secure electronic health records system to ensure timely transmission of emergency records to identified family and/or attending physicians**

Coroner's Comments: *Communication between the emergency departments and treating family physicians and/or attending specialists is inconsistent across the Province. The secure transmission of healthcare information will facilitate continuity of care and assist with optimal health outcomes.*

10. **Given the current wait lists for family physicians and the number of persons in Ontario who do not have a family physician, issue a directive to emergency health care practitioners to provide information relating to community resources available to families seeking advice relating to adolescent substance abuse issues.**

Coroner's Comments: *Counseling was recommended for Christopher Skinner, but since his family did not have a family physician, they had to seek out resources on their own. Testimony from the director of an emergency department supported the provision of information relating to available community resources to the public in the emergency departments of the Province.*

To the City of Hamilton Public Health Service (in consultation with local School Boards, the Hamilton Police Service and relevant drug and alcohol agencies for youth):

11. **To increase public awareness and to engage the community in evidence-based alcohol prevention strategies, develop a local media campaign that:**
    a) **highlights the prevalence of underage binge drinking in the community;**
    b) **highlights the health and social issues associated with alcohol abuse in teens;**
    c) **highlights the subject of this inquest through a video documentary interviewing parties involved;**
    d) **highlights the legal consequences of underage drinking, including allowing minors to drink in your house;**
    e) **highlights the resources available in the community to address issues relating to underage drinking;**
    f) **highlights current misconceptions relating to "accepted' drinking practices;**
    g) **highlights signs and symptoms of alcohol poisoning (e.g. passing out does not equal 'sleeping', when to call 911) and**
    h) **makes available statistics regarding youth's alcohol misuse and how alcohol's misuse can lead to risky behaviours, even death, utilizing the schools' websites as one means of communication.**

Coroner's Comments: *Teenage binge drinking is a Public Health issue and the Public Health Department is the lead in public education efforts. The jury heard that youths are focused on the internet and electronic communication and therefore, the internet should be a focus for education and communication with today's youth.*

To the Hamilton-Wentworth District School Board, the Hamilton Catholic School Board, Le Conseil scolaire Viamonde and Le Conseil scolaire de district catholique Centre-Sud and the Hamilton Police Service:

12. **To ensure enforcement of the *Liquor License Act* and to increase opportunities for the adoption of behaviours that reduce underage drinking, review and consider changes to the current Hamilton Police/School Board Protocol in relation to the notification of police in all instances involving supply of alcohol to a minor and/or all instances of possession of alcohol and/or all instances of intoxication by a minor.**

Coroner's Comments: *Although a protocol exists between the Hamilton Police Service and the local school boards, the protocol does not require that the Police Service be notified in all instances in which 1) young people are found in possession of alcohol or under the influence of alcohol or 2) individuals are found supplying alcohol to persons under the age of 19. Mandatory police notifications send the message that alcohol-related incidents involving minors are serious incidents and need to be treated accordingly.*

13. **To promote a network for parents of youth to discuss risky behaviours, including drinking.**

Coroner's Comments: *A consistent issue identified throughout the inquest was the need to educate and engage parents to assist with dealing with the problem of youth drinking.*

To Alternatives for Youth and ROCK (Reach Out Centre for Kids) and other provincial relevant drug and alcohol agencies for youth:

14. **To ensure that family physicians are aware of health issues experienced by their patients and to increase opportunities for the treatment and care of young people who are engaging in dangerous drinking behaviour, at intake stage obtain complete information relating to a young person's family physician and, if consent is provided, notify the family physician of the young person's reasons for consultation and the outcome of the consultation.**

Coroner's Comments: *Several witnesses in the healthcare field testified that continuity of care is ideal for optimal health outcomes.*

15. **To implement appropriate follow-up procedures to ensure the best possible outcome for the client post-consultation.**

Coroner's Comments: *Not all encounters with young clients at counselling centers are reviewed to ensure that optimal care was delivered. The initiation of a 'case review process' may ensure that clients 'do not fall through the cracks'. The Skinner family was left with the impression that no further appointments were required after the first*

appointment, when indeed, further care was probably warranted. A 'case review' for the Skinner encounter may have resulted in a 'call back' being initiated and ongoing care provided for Christopher and his drinking problem.

To the Ministry of Child and Youth Services:

16. **In an effort to protect children, it is recommended that the age of protection for children be raised to the age of 18 under the Child and Family Services Act.**

Coroner's Comments: *Children aged 16 to 18 are not routinely covered under the Child and Family Services Act and hence, underage drinking may not be routinely reported to Childrens' Aid Services. Raising the age for referral and protection may assist with dealing with underage youths who have recognized alcohol abuse problems.*

Closing comment:

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that the error can be corrected.

Jack R. Stanborough MD
Presiding Coroner
Office of the Chief Coroner
West Region - Hamilton

April 4, 2012

PATRICIA CAMPBELL VERDICTS CLERK JUN 7 2012

Received JUN 07 2012 Deputy Chief Coroner – Inquests

OFFICE OF THE CHIEF CORONER JUN 07 2012 Ministry of Community Safety and Correctional Services