



Office of The Chief Coroner
Bureau du coronier en chef

The Coroner's Act - Province of Ontario / Loi sur les coroners - Province de l'Ontario

Verdict of Coroner's Jury Verdict du jury du coroner

We the undersigned
Nous soussigné

- Carlisle, Ontario
- Hamilton, Ontario
- Hamilton, Ontario
- Ancaster, Ontario
- Mount Hope, Ontario

the jury serving on the Inquest into the death of / dument assermentés, formant le jury dans l'enquête sur le décès de:

| | | | | | |
|--|---|---|--------------------------------|--------------------|-----------------|
| Surname / Nom de famille Osidacz | | Given names / Prénom Andrew | | | |
| aged 41 agé(e) de | Held , Ontario qui a été menée à | at: John | Sopinka | Courthouse, | Hamilton |
| from the du | 2nd of March | to the à la | 9th of April | 20 09 | |
| By Par | Dr. James Edwards | Coroner for Ontario coroner pour l'Ontario | | | |

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

- | | |
|--|---|
| 1. Name of deceased Nom du (de la) défunt(e) | Andrew Osidacz |
| 2. Date and time of death Date et heure du décès | March 18, 2006, 8:46pm |
| 3. Place of Death Lieu de décès | Brantford General Hospital, Brantford, Ontario |
| 4. Cause of death Cause du décès | Gunshot wounds to chest |
| 5. By what means Circonstances entourant le décès | Homicide |

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the _____ day of _____ 20

Original signed by Coroner



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Verdict of Coroner's Jury Verdict du jury du coroner

We the
undersigned
Nous soussigné

- 1. Carlisle, Ontario
- 2. Hamilton, Ontario
- 3. Hamilton, Ontario
- 4. Ancaster, Ontario
- 5. Mount Hope, Ontario

the jury serving on the inquest into the death of / dument assermentés, formant le jury dans l'enquête sure le décès de:

| | | | |
|----------------------------|--|--|---|
| Surname / Nom de famille | | Given names / Prénom | |
| Osidacz | | Jared | |
| aged 8 âgé(e) de | held at Ontario qui a été menée à | John Sopinka | Courthouse, Hamilton |
| from the du | 2nd of March | to the a la | 9th of April 20 09 |
| By Par | Dr. James Edwards | Coroner for Ontario, coroner pour l'Ontario | |

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

- | | |
|--|--|
| 1. Name of deceased Nom du (de la) défunt(e) | Jared Osidacz |
| 2. Date and time of death Date et heure du décès | March 18, 2006, 8:33 pm |
| 3. Place of Death Lieu de décès | Hamilton Health Sciences, McMaster University Medical Centre, Hamilton, Ontario |
| 4. Cause of death Cause du décès | Blood loss due to stab wounds to left neck and left chest |
| 5. By what means Circonstances entourant le décès | Homicide |

Original signed by: Foreman/Président du jury

Original signed by jurors/jurés

The verdict was received on the
Ce verdict a été reçu par moi le

day of

20

Original signed by Coroner

**Inquest into the death of:
Andrew Osidacz
&
Jared Osidacz**

JURY RECOMMENDATIONS

1. **(MAG)** It is recommended that the Ministry of the Attorney General take a leadership role in creating an inter-ministerial committee that will methodically review all community, agency and government domestic violence programs, initiatives to identify redundancies and/or gaps. It is suggested that this committee develop a streamlined and consistent work plan and timeline for developing an efficient and comprehensive approach among all agencies within the province of Ontario. Of particular importance is information sharing amongst individuals and agencies. Issues of urgency and individual safety should be paramount to confidentiality constraints. It is recommended that the final report and plan be made available to the public.
2. **(MAG)** It is recommended that the Ministry of the Attorney General take a leadership role in creating an inter-ministerial committee that will methodically review all community, agency and government responses to recommendations that have been made by the DVDR (since its inception) and related coroner's inquests. It is suggested that this committee develop a work plan and timeline on the implementation of recommendations and consult with the Domestic Violence Advisory Council that currently reports to the Minister of Women's Issues. It is suggested that the final report and plan could be forwarded to the Attorney General and made available to the public.
3. **(MAG)** It is recommended in domestic violence cases a process be developed to efficiently share information among service providers through case conferencing with CAS, police and Crown to ensure timely and effective responses.
4. **(MAG / MCSCS)** The Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services should develop a common intake process for clients of intervention programs and probation that includes an assessment of the client's level of risk of re-offending and/or risk of lethality. This risk assessment should be repeated bi-annually or when there is a change in the caseworker.
5. **(MAG – CLD / MCSCS)** Breaches by domestic violence offenders of peace bond, bail, or probation orders of conditions that provide for no-contact or the completion of an intervention program should continue to be taken very seriously by probation officers and Crown attorneys and should be prosecuted according to Crown policies and practice memoranda. Sanctions such as incarceration, consecutive probation periods and probation terms that provide for increased monitoring should be considered by Crown attorneys in making sentence recommendations for offenders convicted of failing to comply with a probation order or peace bond. All other organizations and individuals involved should be notified of the change in status.
6. **(MAG)** It is recommended that the Ontario Victims Services Secretariat (OVSS) and the Criminal Law Division (CLD) continue their partnership in the Domestic Violence Court Program and explore options for increasing program responsiveness to the subset of domestic violence offenders who are deemed 'highly resistant' to intervention programs such as Partner Assault Response (PAR), either at program intake or during the course of program delivery.
7. **(MAG)** It is recommended that the Ontario Victims Services Secretariat (OVSS) continue and complete its review of the PAR (Partner Assault Response) Program Standards, and that this review include: development of a 'best practice' for assessment of offender's level of denial, minimization and resistance to intervention at intake; and development of options, with associated funding, for alternative programming for domestic violence offenders who are deemed 'highly resistant' either at program intake or during the course of program delivery.
8. **(MAG – OVSS)** Persons who have been identified as being at risk for lethality should be re-evaluated on an on-going basis, including but not limited to termination from, or completion of an intervention program. Further, that copies of such evaluations be provided to other justice partners, including probation and parole, and the CAS, where there are children involved or children in the home of the primary/joint or access parent.
9. **(MAG / OVSS)** The Ministry of the Attorney General should encourage intervention service providers and intervention program providers to seek education and training in motivational interviewing or other techniques to respond to resistant offenders.
10. **(MAG / MCSCS)** Crown attorneys and probation officers should continue to be educated on the dynamic risk and expected actions associated with re-offence and breaches of probation among domestic violence offenders.



11. **(MAG – OVSS)** Upon completion of intervention program(s) mandated as a result of domestic violence it is recommended to develop a process for ongoing contact and support for the perpetrator.
12. **(MAG)** When determining the level of assault to charge the perpetrator of domestic violence with, in addition to the physical injuries sustained, the viciousness of the assault should also be considered.
13. **(MAG – CLD)** Following conviction for an offence related to domestic violence, the Crown should continue to request, where appropriate, that the Court require offenders to complete an intervention program(s) focused on domestic violence.
14. **(MCYS, MAG, MCSCS)** It is recommended that these ministries partner together for the purpose of assessing how to most effectively support intervention programs (such as Caring Dads) which aim to: hold parents/caregivers accountable for exposing their children to domestic violence; and to contribute to the safety of their children and (former) partners. As part of this assessment, consideration should be given to conducting an independent evaluation of the Caring Dads program.
15. **(MCYS, MAG, MCSCS)** It is recommended that, upon successful evaluation of the Caring Dads or similar intervention program, consideration be given to including reference to such program in a Crown Practice Memorandum so that Crown counsel, in appropriate cases where a term of probation is included for an offence involving domestic violence perpetrated by a parent/caregiver who is engaged in a child custody and/or access dispute, may seek a requirement that the offender attend such a program.
16. **(MCYS, MAG, OCL)** It is recommended that after a vicious assault and charges laid the accused is put on bail with supervised access to child(ren) until the courts decide appropriate intervention.
17. **(Ontario Women's Directorate; MAG – OVSS, VWAP)** The OWD, OVSS and/or VWAP should continue to provide education to victims and the public including how to identify increasing risk, how to access resources over time, and the importance of reporting events to police.
18. **(MCSCS)** All probation offices in the Province of Ontario should form 'high risk' teams, together with other partners in the community, such as police, the Crown's office, women's shelters and the CAS to case manage high risk domestic violence cases, particularly those where the offender has been identified as being at high risk for 'lethality'. That such high risk teams partner with mental health professionals in appropriate cases.
19. **(MCSCS)** Intervention programs should be adjusted, where funding permits, to:
 - a. Offer enhanced programming for high-risk clients
 - b. Recognize additional time needed for case planning and risk management
 - c. Allow for ongoing staff training, clinical supervision and higher salaries for program staff.
20. **(MCSCS)** When domestic violence offenders present with or continue to demonstrate, high levels of denial, intervention program providers and probation officers should continue to work pro-actively to manage associated increases in risk. Steps should continue to include case conferencing. Additional phone contacts and/or explicit warnings should be provided to potential victim(s).
21. **(MCSCS)** Probation officers and their supervisors should be directed that an 'anger management program' is not a substitute for a domestic violence rehabilitation program such as PAR.
22. **(MCSCS)** Caseloads of probation officers dealing with intensive supervision offenders, which may include high-risk domestic assault offenders, should continue to be reduced to allow sufficient time for managing the risk of these offenders. Routine supervisory involvement in such cases is suggested.
23. **(MCSCS)** Probation officers should continue to be trained in and be responsive to the elevation in risk associated with an offender's failure to complete intervention programs. Upon failure to complete intervention programs, notification to supervision and other community/legal partners and victims should occur.
24. **(Ontario Association of Children's Aid Societies)** The OACAS Education Services Program should review and assess the extent to which the current training curriculum (as provided in the Foundations of Child Welfare Practice and Advanced Child Welfare Practice) for child protection workers pertains to working with families where there is a history of domestic violence. Particular components of training and expected actions should reference the potential risks for children who are in the custody of or having access to perpetrators of domestic violence.
25. **(Ontario Association of Children's Aid Societies, MCYS)** The OACAS should investigate options for protecting children from harm at the hands of access parents/caregivers who have a history of perpetrating domestic violence against the children's custodial parent/caregiver. Potential options for consideration might include: consultation or case conferencing with the perpetrator's probation officer (if any) to plan



- for risk management and reduction; referring the perpetrator to a program for parents with a history of abuse or of exposing their children to abuse; referring the non-offending custodial parent/caregiver to appropriate services.
26. **(Ontario Association of Children's Aid Societies, MCYS)** The Ontario Association of Children's Aid Societies (OACAS, MCYS) should fundamentally alter its strategy for assessing risk in cases involving domestic violence so that the weight of decision-making rests on risk of harm posed by the perpetrator as well as the capacity of the non-offending parent to take protective action.
 27. **(Ontario Association of Children's Aid Societies, MCYS)** The OACAS and MCYS should develop and implement mandatory screening tool or risk assessment procedures to assist case workers and supervisors in determining the risk of 'lethality' of persons who are involved in a CAS investigation, especially where they have been previously convicted of a domestic violence offence.
 28. **(MCYS)** The Ministry of Children and Youth Services (MCYS) should consider options to amend the Child and Family Services Act, and the regulations thereunder, to include within the definition of a child in need of protection, children who are or may be at serious risk to harm due to a caregiver or access parent's high risk for lethality. Such children may not be directly the victims of physical or emotional harm, but may still be at serious risk for harm.
 29. **(MCYS)** It is recommended that Family Service Ontario and the Ministry of Children and Youth Services work together with local family services agencies in developing and delivering counseling services for persons who are experiencing stress, including following a separation or divorce, or associated with ongoing family or criminal court litigation. Such services should be, as much as practicable, designed for at-risk persons including those with a prior history of violent acting-out in an intimate partner context.
 30. **(MCYS)** It is recommended that when assessing risks with respect to Child and Family Services Act and Eligibility Spectrum a child that is on the premises where the assault occurs should be considered the same as a child witnessing the assault.
 31. **(Office of the Children's Lawyer)** All lawyers and clinical investigators who do work for the Office of the Children's Lawyer should continue to receive education and training on issues of domestic violence, risk assessment and associated safety concerns for children.
 32. **(Office of the Children's Lawyer)** In cases involving domestic violence, clinical investigators should, in appropriate circumstances, consider recommending supervised access of children until intervention programs, or parenting or co-parenting programs have been successfully completed.
 33. **(Office of the Children's Lawyer)** Clinical investigators should request the consent of parents to share their investigation reports with probation officers where applicable.
 34. **(EMS)** It is recommended that all emergency response personnel (EMS) carry portable two-way radios to ensure effective communication.
 35. **(EMS)** It is recommended that, at a minimum, one person in each ambulance response unit is certified as an Advanced Life Support (ALS) paramedic.

