



3. Amanda Simpson

Amanda Simpson was born on December 16, 1994. Amanda was Métis. The Ministry had received numerous complaints involving neglect and abuse, including complaints from the Simpson children themselves and from professionals involved with the family. Amanda died as a result of head and internal injuries on November 2, 1999. She was four years old. A coroner's inquest in June 2007 classified her death as a homicide. A criminal charge was laid and later stayed.

The Ministry had its first contact with Amanda's mother as a parent in January 1991. A family service file had been open to provide Amanda's mother's family of origin with services to address issues of neglect and alcohol abuse. The file was closed in January 1991. At the time, Amanda's mother was 17 years old and had just given birth to her first daughter. They lived in Prince George.

On February 12, 1991, the Ministry received a call reporting concern about an infant being neglected; specifically, it was suggested that she was being left unattended and was not being fed properly. The Ministry received another report on March 7, 1991, which alleged physical and emotional abuse of the infant. The child protection investigation that followed found that the infant was "at certain risk."

The Ministry assigned a teaching homemaker to the family to provide the young parents with assistance in caring for their infant and to instruct them on safe parenting. The couple accepted the services of the homemaker for six months, but declined counselling and other supportive services. A second child was born in 1993.

Homemaker services

The Ministry had regional contracts with various homemaking agencies to provide a variety of services. In some cases the primary role of a homemaker was to help with household tasks, while in others the emphasis was more on teaching homemaking and child care skills; most cases involved some combination of these roles. The teaching homemaker assigned to work with the Simpson family was tasked with assisting the parents in learning how to feed and care for an infant. The homemaker provided the Simpson family child protection worker with periodic verbal updates on the parents' progress in learning these skills.

Between February 1991 and June 1994, the Ministry received 15 calls related to the family. Of these 15 reports, 13 were assessed and designated as requiring an investigation. Identified concerns included allegations of neglect and abuse, including physical, sexual and emotional abuse. In addition, the Ministry and police received persistent reports of domestic violence. Two of the reports (September 1991 and June 1993) were incorrectly designated as Requests for Services. Of the 13 reports designated as requiring an investigation, three were investigated and for the most part were not completed to the standards of the day.

Amanda's parents separated in 1993. No child protection reports were made to the Ministry between June 1994 and September 1997. It is not known if circumstances changed for the family during these three years. Child protection staff suspected that the family had moved out of province, but the coroner's inquest in 2007 heard that the family remained in Prince George during this time.

Amanda was born on December 16, 1994, at Prince George Regional Hospital, the third of the couple's four children. Amanda's mother received no prenatal care. The hospital staff was unaware of the family's history with the Ministry or the history of domestic violence. The attending physician wrote that the mother was comfortable and confident in handling Amanda. Amanda was sent home with her mother and maternal grandparents. It appears that Amanda and her sisters lived with their maternal grandparents for a time. The fourth child was born in 1996.

The first new report about the family was received by the Ministry in September 1997, when Amanda was two years old. The oldest sister, then six years old, reported that she was frequently the only caregiver for her sisters, ages one, two and four years. She complained of a headache and was very tired. She also requested some help with caring for her sisters. The child was able to describe in detail a meal and bedtime routine she had created to keep her sisters quiet: she fed them "freezies and ice cream" and played with them. The child described a past incident in which one of her sisters had set off the fire alarm while playing with a lighter. She said that the girls were cold and wanted to start a fire to warm up. The fire department reportedly attended the home.

The child protection worker was concerned about the home environment and began an investigation. On September 11, 1997, this worker interviewed the child and passed the case on to a second child protection worker for completion. The intake was not registered on the new electronic case management system. When interviewed, the child confirmed that she was often in charge of her sisters and looked after them when her parents were out of the home, that they were often cold and hungry, and that "mom and dad were fighting, dad hurts mom" and they were scared.

The electronic management program was a new resource to support case management activities by social workers. When the office was later audited, in December 1998, there were many unfinished intakes requiring completion. The handwritten notes of the child protection worker indicated that some of the steps for an investigation had been completed; however, they were not entered in the new system.

The second child protection worker made a home visit and spoke with the mother. This interview was minimally documented and does not address the significant child protection issues disclosed by the child. Documentation on the file suggests that the second worker was unable to follow up and assess the information about the family because of workload issues. The child protection worker left the Ministry and the investigation was not completed. The file was still open when an additional report was made a year later.

On September 21, 1998, a caller reported to the Ministry that she had observed the mother smoking "a lot of pot" and yelling at her children. The caller reported that there were times when there was not enough food in the house, and alleged that the mother had assaulted a neighbour and that the RCMP were involved. This new report and the file was assigned to a third child protection worker.

Sometime in 1998, a new man became involved with the mother. He has subsequently become her partner. Although it is not certain where he lived at this time, it was believed that he maintained a separate residence and was also resident in the Simpson home.

The investigation of the September 1998 report was reassigned to a fourth child protection worker on February 15, 1999. This child protection worker was part of the "float team" that was given a number of cases to complete. By this time she was responsible for following up on both intakes.

The fourth child protection worker began by finishing the September 1997 intake and sought consultation with the first child protection worker responsible at the time. The child protection worker then made a home visit, and learned that the parents had separated and that mother did not want services. No specific details were documented regarding the child protection issues.

Regarding the September 21, 1998 report, the child protection worker telephoned the Child Development Centre on February 15, 1999 and spoke to one of the supervisors who was involved with the three sisters. Three of the sisters attended the Child Development Centre. The supervisor reported that the girls were appropriately dressed and that the Centre had a good relationship with the mother.

Staffing issues in the Ministry's North region

During this period, the North region of the Ministry was experiencing significant human resource challenges. There was a high annual staff attrition rate. In the second half of 1998, 21 child protection, resource and guardianship workers had been hired. By October 1999, 10 of those staff had resigned. Only 161 of the 222 staff positions for child protection, resource and guardianship worker positions were filled. Approximately 30% of those workers had less than two years experience. In seven offices in the North region less than half the staff were permanent. Temporary workers filled some positions, while other positions were left vacant.

The Ministry Director's case review indicates that:

...between September 1998 and December 1998 the Prince George Child, Family and Community Service offices were audited. The audits identified a number of practice issues including the identification of some caseloads that had been minimally managed. As part of the regional response, all caseloads were reviewed and the outstanding work was prioritized for completion.

In December 1998, the four Prince George office teams were reorganized to comply with the provincial model of specialized child protection intake and investigation teams and separate family service teams. The Ministry headquarters sent a group of social workers to the North region to assist with child protection file investigation and closure. The group was called a "rapid response team," and was used in the North region and elsewhere in the province where staffing challenges prevented timely investigation of child protection reports.

The RCMP advised the child protection worker that Amanda's mother would be going to court on assault charges. It was the officer's opinion that this incident represented an ongoing dispute between Amanda's mother and the individual who had reported concerns about the children. The child protection worker assigned to the file called the family physician to ask about any injuries the mother might have sustained during the assault. There was little information on the medical file about the mother or the children.

The child protection worker also called the school and spoke to each of the teachers of the two eldest sisters. Neither teacher expressed concern about the girls' attendance or participation in school. One of the teachers had not met the mother. The other teacher told the social worker that the mother was "cooperative, positive and open." The child protection social worker also contacted the Child Development Centre, where three of the sisters participated in programs. The five-year-old attended kindergarten and daycare. The other two sisters attended daily and were reported to have been appropriately dressed.

Child Development Centres

Child development centres generally deliver a cluster of specialized services for children with special needs, including diagnostic, developmental and intervention services. Child development centres provide one or more of the following Ministry-funded services: Early Intervention Therapies, School-Aged Therapies, Autism Intervention, FASD Key Worker Services, Infant Development and Supported Child Development.

In rural areas, multiple services tend to be clustered in child development centres (as was the case in Prince George). While the total number of agencies providing these services is not easy to identify, there are 43 agencies in British Columbia delivering at least two of the following: Early Intervention Therapies, Infant Development and Supported Child Development. The British Columbia Association for Child Development and Intervention (BCACDI) represents approximately 25 agencies that provide services for children and youth with special needs.

Child development centres and other agencies delivering services for children with special needs and their families are primarily funded through contracts with the Ministry. Other sources of funding include foundations, individual and business donors, school districts and health authorities.

Following consultation with the supervisor on March 1, 1999, the child protection worker also went to the home and noted that "the home was impeccable, clean, tidy and well furnished." The mother reported that the children were in their rooms having a "quiet time" after school and two were napping. The children were not seen. The child protection worker also noted that there was food in the house and that the mother was co-operative. As a result, the child protection worker concluded that the family was not in need of services and that the children were not in need of protection.

The September 1997 and February 1998 intakes were also signed off on March 1, 1999. The supervisor noted his concern about the family's history of involvement with the Ministry in a notation on the file, but no plan was made to follow up and/or monitor the family.

On March 24, 1999, the Ministry received a report about abnormal bruising observed on the thighs and buttocks of one of the younger siblings. The caller noted significant behavioural changes in this child: she was soiling herself (when she had previously been toilet-trained), complaining of aches and pains, hoarding food and toys, and clinging to her mother.

The report was designated a child protection report and investigated. The children were interviewed on March 25, 1999. They reported being spanked and having their mouths washed out with soap by their "secret dad." Collateral interviews were also completed with both of the elder sisters' teachers. Amanda's teacher reported small behavioural changes. Amanda was interviewed and disclosed that she was spanked by her mother and stepfather and made reference to a spoon. The child protection worker noted that she was difficult to interview. When the worker spoke with the mother the next day, she denied that the children were spanked and stated that the man the girls were referring to – her new partner – did not live with them. He was not interviewed and no effort was made to determine whether he did live with the family.

On March 26, 1999, another report was made to the Ministry involving bruising on the two-year-old sister of Amanda. The child protection worker followed up with the medical clinic to find out whether the mother had sought medical attention for her daughter, and learned that the mother had been turned away. He also checked with the Prince George Regional Hospital and learned that the mother had sought medical attention for the two-year-old child, who had reportedly injured her finger in a car door as well. The child protection worker was concerned about hearing a report of another injury.

On April 6, 1999, the mother took the children to a clinic for medical examination. The child protection worker contacted the clinic and spoke with the physician who had seen the children. The physician who saw the children had not observed any bruising but agreed to follow up with a comprehensive medical evaluation of the children and indicated that she would alert the Ministry if she had concerns. It appears that this physician did not see the children again and eventually ceased working at the clinic. The police were not notified.

On April 7, 1999, the worker spoke with Amanda's mother again by phone. The mother said that her partner had left the home because he was upset about the allegations. The worker documented that he felt she was not being truthful, but might have been afraid she would lose her Income Assistance if it became known that she had a live-in partner. The intake file was closed. The children were found to be safe in their mother's care.

On May 11, 1999, the Ministry received a report involving concerns about Amanda's sibling. The reporter was concerned that Amanda's sibling was afraid to go home because her mother was going to beat her up after school as a punishment for stealing food. Amanda's sibling said that her mother had hit her with a hairbrush that morning before she left for school.

This report was accepted for investigation by the child protection worker, who then interviewed the sibling. The sibling told the child protection worker that her sisters were not hit by either their mother or stepfather.

The child protection worker contacted the mother by phone. The mother told the worker that everything was fine at home. She acknowledged the incident involving the theft of food and told the worker that her daughter was upset when she was caught. The mother denied hitting her daughter with a hairbrush and said she did not know how the child had misinterpreted the situation and was afraid to go home. The mother also stated that all of the children had been seen by a physician and were fine. The worker did not follow up with a home visit to interview the mother and the other sisters separately.

The worker did follow up with school staff, who reported that they understood that the girls lived downstairs and that it was the eldest sister's job to take care of her sisters and keep them quiet.

The investigation was concluded and the immediate safety assessment was completed, with a finding that the children were safe. There was no finding that the children were in need of protection. The intake was signed off by the Acting District Supervisor and later by a second supervisor (sign-offs by acting supervisors also required sign-off by a second supervisor).

On June 21, 1999, another report was received by the Ministry citing marks and bruises on one of the siblings. The reporter indicated that the child had been regressing in speech and toilet training. The reporter also expressed concern about previous child protection issues that had been reported and discussed with Ministry staff, but that persisted.

On June 22, 1999, the child protection worker interviewed a sibling who denied any spanking and spoke positively about the home. Another sibling was also interviewed and gave conflicting statements about being hit by the stepfather. Amanda was interviewed and indicated that their stepfather lived with them and walked her home from daycare. The child protection worker observed a bruise on Amanda's lower back.

A pediatrician examined a sibling on June 22, 1999. Ministry files indicate that background information was provided by the clinic coordinator and the child protection worker, but do not specify what this information consisted of. The medical examination found two tiny yellow-brown bruises on the child's lower back and upper stomach area. The other medical findings were reportedly within the normal range. Recommendations were made regarding the treatment of a cold and possible asthma. A medical-legal report was sent to the Ministry and received on July 2, 1999.

The pediatrician also examined Amanda and diagnosed her with "failure to thrive" because of her small size. She was reported to be below the fifth percentile for average growth in her age group. The medical records do not indicate whether this marked a change from her previous rating on the growth chart, but the pediatrician was concerned. There is no indication that the pediatrician consulted Amanda's previous medical records or contacted a physician who had examined her in the past. It appears that this might have been a difficult

task, because the family used walk-in clinics for medical care and did not have a consistent medical caregiver. Further testing was suggested but not completed. The pediatrician also indicated that the bruises on Amanda's back were not due to abuse and confirmed the "failure to thrive" diagnosis in a report received by the Ministry on July 23, 1999.

Amanda was examined by another pediatrician on June 23, 1999. Amanda said the bruises were the result of being pushed by her sibling onto a lawnmower. She denied being spanked. Amanda's mother had no explanation for the bruises.

The child protection worker met with the mother on June 28, 1999 to discuss the concerns. The mother's new partner was invited and did not attend. The mother indicated that her new partner did not live with them and that he almost never disciplined the children. The mother also denied physically disciplining the children and suggested that the children were confused by incidents from the past when she was in an abusive relationship with the children's father. The significant behavioural and physical changes in one of the siblings were not discussed.

On July 16, 1999, the child protection worker phoned the medical clinic and was advised that the older children had been seen and the physician was away. The pediatrician phoned the child protection worker on July 23, 1999, and indicated no concerns. The electronic intake report indicates that on this same date, a comprehensive risk assessment was completed by the child protection worker. The overall risk rating was "low." The intakes were signed off by the worker on July 23, 1999, with a finding that the children were not in need of protection, and signed off by the supervisor on July 27, 1999.

In October 1999, there were two additional reports of physical injury, one on October 8, and a second on October 29. Both reports involved injuries to one of Amanda's siblings including unexplained bruising. The first one was designated a child protection report. The child protection worker interviewed the child and found her to be "unfocused, inconsistent and somewhat dramatic." The child protection worker was unable to confirm that the child said anything about having a bruise. Other child protection workers had similarly assessed the child as not focused and inclined to exaggerate.

The eldest sister was also interviewed and stated that bruises on her sister's forehead were caused by her hitting her head on the headboard of the bed. She also indicated that her sister "told stories." The child protection worker followed up with staff at the Child Development Centre, who restated that the child was genuinely upset about the idea of going home that morning.

The child protection worker went to the children's home and spoke briefly with the mother. The worker confirmed with her that the two older girls had been interviewed and that there were no disclosures and no concerns. The mother did not recall the child complaining of a headache. She also stated that the children had had recent medicals and

that the subject child did tell stories. The mother indicated that Amanda had a follow-up appointment with a pediatrician after Christmas. The mother also indicated that she had called about some counselling, but no one had returned her call.

This intake was registered to be closed as there was "no evidence of physical harm or likelihood" and signed off by the worker on October 18, 1999. The supervisor had not yet signed it off. The worker noted on the intake record that "Reports coming from [this child]...need to be carefully assessed as to whether an investigation is necessary."

The Ministry Director's case review found that Amanda had been seen at the medical clinic on September 30, 1999. The pediatrician expressed concerns regarding possible sibling violence, as Amanda presented with bruises on her chest, back and knees. Amanda had indicated that she was pushed by her older sibling. The pediatrician reportedly spoke with the mother to express her concern about this. There was no previous information about a sibling being violent toward the other siblings. This information was not reported to the Ministry.

On October 29, 1999, Amanda's sibling reported being hurt by her mother's partner. The child reported that her finger was injured when she was hit. She was crying and upset, making statements including "please save me."

The reporter expressed concern this was the second time in three weeks that they had informed the Ministry of suspected abuse. The child protection worker informed the caller that she was not concerned. She suggested that the individual call the mother and discuss any concerns with her directly. The worker stated that she was not going to investigate, and suggested that the child needed counselling about "truth and fiction."

The individual who reported the child's injury was unsatisfied with this response and faxed a record of observations of the injuries to the Ministry office late in the afternoon of October 29, 1999. The file for these incidents was still open the next day, when Amanda was admitted to hospital.

On October 30, 1999, at 11:20 p.m., Amanda's mother and her partner brought Amanda to Prince George Regional Hospital by car. Amanda was in a coma, with massive head and abdominal injuries. She was very cold, had numerous bruises and was making little effort to breathe.

Amanda had been home with her mother's partner that evening, while her mother was working. Hospital admission records show that the explanation for Amanda's condition provided by the mother's partner at the hospital was the following:

- The family had supper around 6 p.m.
- Amanda was playing downstairs with her sisters and fell or was pushed off the top bunk bed, possibly striking her head during the fall. The time of the injury was not known.

- The partner heard a child crying and went downstairs to investigate.
- He found Amanda unconscious, with a nosebleed and a swollen head, and she was vomiting.
- He brought her upstairs, laid her in a bed and put a bag of frozen vegetables on her head to reduce the swelling.
- He called Amanda's mother at work and asked her to come home.
- When the mother arrived home, they drove Amanda to the hospital.
- The time between the injury and hospitalization was not known, but the mother's partner thought it was possible that Amanda was injured around 8 p.m. (more than three hours before Amanda was taken to the hospital).

The Ministry and the RCMP were notified, because the physicians who were treating Amanda found the explanation to be inconsistent with the severity of her injuries. The mother's partner was described by physicians as inebriated. He told police that he had consumed about five beers and a couple of shots of hard liquor before heading home at 6 p.m.

Examination at the hospital in Prince George revealed that Amanda had a severe skull fracture with associated bleeding in the brain. Some of the injuries were consistent with shaking. For example, there was bleeding in both retinas and the optic nerve sheath. Amanda also had a fractured collarbone and severe abdominal injuries consistent with blunt force trauma. There were numerous bruises on her body. One physician likened the injuries to those of a person who had been in a serious car accident while wearing no seatbelt. Because of the severity of her injuries, Amanda was later transferred to BC Children's Hospital Intensive Care Unit.

Amanda died on November 2, 1999 at BC Children's Hospital. The pathologist who did the autopsy concluded that Amanda's injuries were not accidental but consistent with inflicted trauma.

Reviews and investigations

Police investigation

In the days and weeks following Amanda's injury and death, the police interviewed a number of individuals, including the babysitter who cared for the Simpson children after Amanda was admitted to hospital, and relatives and co-workers of Amanda's mother and her partner.

Amanda's mother provided the police with limited information. When asked about her involvement with the Ministry, she described two interactions with the Ministry and stated that everything was fine. She said her children had been referred to a program for children who witness violence but that they did not go. The police did not have the Ministry file about the family and it does not appear that they requested this information.

Amanda's siblings, ages eight, six and three years, were interviewed by police several times. The information that the children provided was inconsistent. The police officers could not determine whether the story the children told about the events on the night Amanda was injured had happened on that date or at other times. The children were not able to differentiate between past instances of abuse and the events of the night that Amanda was critically injured.

Amanda's mother's partner reported that he didn't know how the initial injury had happened. He said that the older child dragged Amanda upstairs in an unconscious state, Amanda vomited and he carried her to the bathroom. He wanted to put her in a cold shower to keep her awake, because he had heard that that was what should be done for people with head injuries. He said he slid on the bathmat and dropped Amanda into the bathtub (or possibly onto the side of the tub) and fell on top of her. She didn't wake up. He showered her until his hands were cold, about three to five minutes. Amanda didn't wake up. He called Amanda's mother at work and asked her what to do.

He was charged with a criminal offence pertaining to Amanda's injury but not her death. The charges were stayed after Amanda died. No criminal charges were laid in connection with Amanda's death. The police investigation concluded in April 2004.

Ministry reviews

Six weeks after Amanda died, the Ministry completed a Director's case review, which involved staff interviews and a review of the complete file. The review resulted in 12 recommendations. The review is discussed in greater detail later in this report.

The Ministry completed a management review which resulted in two staff members being disciplined; one was reassigned and one was suspended.

Coroners Service investigations

The Coroners Service

The Coroners Service of British Columbia is responsible for the investigation of all unnatural, sudden and unexpected, unexplained or unattended deaths.

The coroner is responsible for ascertaining the facts surrounding a death and must determine:

- the identity of the deceased, and
- how, when, where and by what means the deceased died.

The death is then classified as:

- natural – a death resulting primarily from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors
- accidental – death due to unintentional or unexpected injury; includes death resulting from complications reasonably attributed to the accident
- suicide – death resulting from a self-inflicted injury, with the intent to cause death
- homicide – death related to the deliberate actions of another person; does not imply blame or guilt
- undetermined – a death that, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

These classifications are consistent with the World Health Organization's system of death clarification.

When Amanda Simpson died in 1999, the Coroners Service's practice was to wait until all criminal processes had been completed before proceeding with its investigation. Amanda's death was also reported to the Children's Commission. An investigation was not completed by the time the Commission was disbanded in 2002.

The coroner provided the police with information about the cause of death and shared autopsy and toxicology reports. During the police investigation, there was significant consultation between the police and the coroner about the nature of Amanda's injuries.

The Coroners Service Special Investigations Unit reviewed Amanda's case in November 2001 and concluded in March 2002 that Amanda's injuries were consistent with "non-accidental inflicted traumatic injury," meaning that they were intentionally inflicted by another person. In January 2003, Amanda's file was transferred to another coroner while the police continued their investigation.

In April 2004, the coroner met with police and was advised that Crown counsel had not approved criminal charges in the case. The police requested that the coroner convene an inquest. According to information provided by the Chief Coroner, the coroner assigned to the case did not complete interviews with witnesses between 2004 and March 2006 because that coroner was uncomfortable doing those interviews.

Special Investigations Unit

In 1999, the Coroners Service had a Special Investigations Unit staffed by a full-time coroner (a Registered Nurse) and team of medical investigators (also Registered Nurses). The staff in this unit reviewed deaths involving more complex medical issues, advising the coroner as to the content of the public report and making suggestions for recommendations to resolve systemic medical issues. The unit was reorganized in 2004 to include a full-time coroner with specialized pediatric knowledge and field experience, and the services of a Chief Medical Consultant.

The Child Death Review Unit

The Child Death Review Unit of the Coroners Service reviews the deaths of all children age 18 and under in British Columbia once the coroner has closed the file, in order to:

- better understand how and why children die
- use those findings to prevent other deaths and improve the health, safety and well-being of all children in British Columbia, and
- gather data that can show trends in child deaths.

The Coroners Service also attributed the delays in Amanda's case to challenges in its case management system. Cases were not effectively tracked for compliance with case completion time frames. The Coroner's management team decided to delay the inquest until the Hughes review was complete. During the delay, the file was reviewed by the Coroners Service Child Death Review Unit. The file was transferred between two additional coroners before the inquest was completed in June 2007. The necessary interviews of witnesses in the case were completed before the inquest took place.

Coroner's inquests

When the coroner is finished investigating a death, the work is completed with either a written public report or an inquest. A written report includes the cause, classification and circumstances of the death and may include recommendations. The Chief Coroner has discretion to convene an inquest, or the Attorney General may direct the Chief Coroner to convene an inquest into an individual's death. Some inquests are required by legislation (the *Coroners Act*), as in cases where an individual dies in the custody of the police. Inquests may also be convened if the investigation of the death determines that it would be beneficial in:

- addressing community concern about a death
- assisting in finding information about the deceased or circumstances around a death, and/or
- drawing attention to a cause of death if such awareness can prevent future deaths.

Inquests are formal court proceedings, with a five-person jury, held to publicly review the circumstances of a death. The jury hears evidence from witnesses under subpoena in order to determine the facts of the death. The presiding coroner is responsible for ensuring that the jury maintains the goal of fact finding, not fault finding. The Verdict at Inquest includes the jury's classification of death and wherever possible its recommendations on how to prevent a similar death.

Although the inquest process is non-fault-finding, the public hearing of evidence provides some public accountability for agencies like the Ministry and the police.

Coroner's inquest

A coroner's inquest was held June 11–15, 2007. The jury classified Amanda's death as a homicide, which does not imply individual blame or guilt, as would a criminal or civil proceeding, but rather attributes her death to intentionally inflicted injuries. The jury made four recommendations, which are included in Appendix E.



4. Savannah Hall

Savannah Hall was born on September 9, 1997. A First Nations child, Savannah was in the Ministry's care from the age of eight months. For most of her life, she lived in the same foster home. Savannah died on January 26, 2001, as a result of extensive brain damage caused by lack of oxygen to her brain. She was three years old. A coroner's inquest in November 2007 classified her death as a homicide. No criminal proceedings were undertaken following her death.

Savannah's mother is a member of the Lake Babine Nation, in the Burns Lake area. The mother had a difficult childhood that involved abuse, neglect and removal from her parental home by the Ministry. She struggled with issues related to substance abuse, transience and domestic violence.

Savannah was born in Prince George on September 9, 1997, when her mother was 18 years old. As a condition of retaining custody of Savannah, her mother and Savannah stayed with a relative after Savannah's birth. The Ministry removed Savannah from her mother's care on October 16, 1997, when the mother advised the Ministry that she had moved from her relative's home and assumed responsibility for Savannah, contrary to the safety plan implemented at the time of Savannah's birth.

On November 5, 1997, the court returned Savannah to her mother's care under an interim supervision order. On February 6, 1998, Savannah's mother requested that Savannah be placed temporarily in care so that she could "straighten her life out." Savannah's mother admitted herself to detox, and Savannah was taken into care.

A **supervision order** is made by the court to ensure a child's safety when the child is returned home and to address ongoing maltreatment concerns (Section 41(1)(a) of the *Child, Family and Community Service Act*, 1996). A supervision order can have a number of conditions, such as regular scheduled and unscheduled visits with the family, mandatory parental attendance in a drug treatment program, family counselling, and anger management training.

On March 10, 1998, the court ordered Savannah returned to her mother's care under a six-month supervision order which had a number of terms including completion of a parenting program and counselling for alcohol and drug abuse and demonstrating stability in her personal life. The Ministry removed Savannah again on April 14, 1998, claiming that the mother was non-compliant with the terms of the supervision order. On May 7, 1998, the court found that the mother had not violated the terms of the supervision order and ordered Savannah returned to her mother's care.

A child protection investigation found Savannah in need of protection due to neglect; consequently, she was removed from her mother's care again on May 27, 1998. Savannah was placed with a foster family in the Prince George area.

On September 28, 1998, Savannah was moved to a second foster home, where three other children in care resided. Documentation in the file indicates that the move to the second foster home was originally intended to be a short-term placement for "respite" purposes. However, once Savannah was placed in the second foster home, no other placement plans were pursued.

The foster parents in Savannah's second foster home became foster parents in May 1989. Annual reviews of the foster home completed up to and including 1996 were consistently positive. The notes in the foster home file from 1997 to 1999 indicate that Ministry staff solicited and relied heavily on the foster mother's advice and opinions regarding medical care and appropriate placement of the children who had been in her home. As the Regional Child Protection Manager testified at Savannah's inquest, the foster parents were "trusted foster parents for a long time" with the Ministry.

In June 1997, prior to Savannah's placement, the Ministry received a report that children who had previously been in the foster home received cold showers and had their mouths washed out with soap as punishment. The foster mother denied the allegations. The resource worker who investigated the allegations by interviewing the children and the foster mother determined that they were unsubstantiated.

On January 14, 1998, the Ministry received a report from a residential assessment centre for children. The report was that a child alleged that the foster mother had disciplined her with cold showers and soap in her mouth. The guardianship worker interviewed the child and her brother, who also reported being put in cold showers and sent to his room for long periods of time when he was bad. The resource worker discussed concerns arising from the interviews with the foster mother, who again denied the allegations; the worker recommended continued use of the foster home.

The foster parents had been assessed and had received approval in 1992 for caring for children with more specialized needs, but not for children with severe mental or physical disabilities. The Ministry's review of Savannah's death later found that there was little evidence in the 1992 assessment to support the foster parents' ability to provide care for a high-needs child.

The files indicate that the foster parents wanted to care for children who were "reasonable" and "manageable." Soon after they were approved to care for children with special needs, the foster parents cared for a special needs child who screamed frequently. The placement was short-lived, as the family could not tolerate the child's behaviour. The file indicates that they stated they would not welcome the placement of a child with similar behaviour. They preferred to have children who were "workable."

In October 1998, shortly after Savannah's placement in the second foster home, a speech pathologist found that Savannah had delays in speech and personal/social development. Savannah was 13 months old. She was placed on an estimated two-year wait-list for speech therapy at the Health Unit.

Infant Development Program

The Infant Development Program serves children from birth to three years old who are at risk for or already have a developmental delay. Programs are available in communities throughout British Columbia, and are supported by the Ministry of Children and Family Development. Each program brings parents and professionals together to help children overcome developmental difficulties. Each local program works in partnership with a range of other professionals in the community. Services may include home visits, developmental assessments, playgroups, parent workshops and support groups, therapy consultation, and service coordination.

On December 10, 1998, the infant development worker (from the Infant Development Program) made her first visit to Savannah's second foster home. The infant development worker assessed Savannah and determined that she was experiencing global developmental delays ranging from two to eight months in different areas.

The infant development worker documented concerns about Savannah's foster home placement and communicated her concerns to Savannah's guardianship worker and Ministry team leader (supervisor). She recommended that Savannah receive more one-to-one care and attention and be assessed by a pediatrician. She was concerned that Savannah's development had regressed since her placement in the home two months before, and felt that Savannah was showing signs of neglect and possible abuse. The foster home, she believed, was too busy to meet Savannah's developmental needs.

The Ministry team leader reviewed the infant development worker's concerns with the Regional Child Protection Manager, who recommended that Savannah see a pediatrician as soon as possible. There is no indication in the file that this recommendation was acted upon. After the foster mother received the infant development worker's report and recommendations, she contacted her resource worker to report that she had reservations about working with the infant development worker. The foster mother believed that the assessment was flawed and rushed.

The issue was taken to the Regional Child Protection Manager, who expressed "every confidence" in the foster home. In an email to staff, he reminded them that "it is for the child's care we come together" and that staff should keep their personal feelings out of the situation. He did not support a change in Savannah's placement.

Soon after this discussion, another guardianship worker visited the home with a second infant development worker. The guardianship worker and the second infant development worker found that Savannah made good eye contact with the foster mother. They agreed with the foster mother and concluded that the original assessment was flawed. The infant development worker was changed, and the medical assessment suggested by the first infant development worker was not completed.

In January 1999, the new infant development worker attributed Savannah's delays in growth and development (four to five months behind her chronological age) to "change" and recommended that any future changes, such as an alternative placement, be undertaken gradually.

Social workers

All social workers who work in the child protection, family service and guardianship areas have different types of responsibility and authority under the *Child, Family and Community Service Act* and/or the *Adoption Act*:

- **Child protection social workers** collect information, respond to child protection reports, conduct child protection investigations, remove children, attend court and work with families to plan for the return of children or for continuing custody.
- **Guardianship social workers** manage the Director of Child Protection's role as guardian of children in **care**.
- **Resource social workers** are responsible for the recruitment and retention of foster homes, group homes and other residential and non-residential services.
- **Adoption social workers** manage adoption planning and placement of children for adoption with prospective adoptive parents.

On March 3, 1999, the guardianship worker for another child in the foster home contacted the resource worker to report concerns about child management methods used by the foster mother. The foster mother had reportedly brought the child to school in his pyjamas when he would not follow her directive to get dressed. The child was reportedly not allowed to sleep in his bedroom for a month and was having to sleep on a cot in the hot tub room because he had got up in the night to eat candy. The resource worker discussed these concerns with the foster mother and sent the foster home a letter in April 1999, reviewing the standards for foster children's bedrooms.

Also in April, Savannah was referred by the Infant Development Program for occupational therapy.

In May 1999, the number of children in the foster home rose to six, with four children in care, one infant placement pending adoption, and one natural child. On May 21, 1999, another infant was placed in the home for two weeks. The resource worker requested, and received, an exception to policy, as the foster parents were now caring for three children under the age of two. An exception to policy is required when there are more than two children under the age of two years in a foster home.

At this time, Savannah was 20 months old and began attending a day program at the Child Development Centre in Prince George. On admission to the Child Development Centre in May 1999, she was examined by a pediatrician, occupational therapist, psychologist and other members of the Centre's multidisciplinary staff. She was found to have delays in speech,

fine motor skills and social skills. She was assessed as needing speech and occupational therapy as well as physiotherapy to address her global developmental delays. Her name remained on the wait-list for speech therapy at the Health Unit.

On July 27, 1999, the foster mother asked the Ministry for a reassessment of her fostering contract. She stated that she felt Savannah was a special needs child and she therefore should be paid at a Level 2 rate. The foster mother reported that she was spending all her time looking after Savannah. She described Savannah as throwing toys and biting; she was "hard to take anywhere, a fussy eater, she had broken a crib and a playpen, ripped a mattress apart, and only seemed happy when fed." The furniture was reportedly destroyed during the night, when Savannah had "night terrors." Savannah's escalating behaviours, as described by the foster mother, were not examined by Ministry staff or a physician until more than one year later.

The Acting Community Services Manager denied the foster mother's request to be paid at a Level 2 rate for Savannah's care because, at this time, the foster home already had Level 2 contracts for three children in care and had recently adopted a newborn. The Acting Manager wrote, "I believe the reason behind only allowing so many children in a leveled home is because of the level of difficulty and the interactions become more complex as the number of children increase." An exception to Ministry policy would have been required to approve a fourth Level 2 contract. In response to the foster mother's request, the Ministry provided the foster home with the assistance of a homemaker for a few days a week.

On September 7, 1999, the resource worker requested a fourth Level 2 contract. This time, the Acting Community Services Manager provided temporary approval for three months based on the resource worker's recommendation. The Acting Community Services Manager subsequently renewed approval of a Level 2 contract until March 31, 2000.

By February 2000, the foster mother was having difficulties coping with the child whom the guardianship worker had been concerned about in March 1999 in relation to the foster mother's child management methods. This child had been in the foster home for nine years. The guardianship worker wrote, "She [the foster mother] is not coping well and [the child] is bearing the weight of this." The child was placed in a treatment facility in Prince George in mid-March 2000. He did not return to the foster home.

On August 10, 2000, a child protection worker visited the foster home to discuss the placement of another child. The worker noted that a piranha fish was kept in an uncovered tank. The worker observed that Savannah's bedroom was a dark, windowless room in the basement which was contrary to standards. The foster mother explained to the worker that Savannah was kept away from the family at night because her screaming would often wake family members. The worker also discovered that Savannah was being harnessed at night with a commercially made leather walking harness for children.

On August 16, 2000, the child protection worker's concerns were forwarded to Savannah's guardianship worker and the team leader. Both wanted to investigate the issue of the harness and referred the matter to the Regional Child Protection Manager, who did not support an investigation or a review of the quality of care in the foster home, but wanted to address the issues on an informal basis. An August 17th e-mail in the file documents the Regional Child Protection Manager's opinion that the foster parent would likely have received advice from a professional or done some "research" regarding the use of the harness.

The Regional Child Protection Manager recommended to staff that the foster parent discuss the matter with a pediatrician and asked staff to follow up.

On August 23, 2000, the guardianship worker and resource worker met with the foster mother to discuss the harness. The foster mother explained that she had been using the harness for some time because Savannah would shake cribs and playpens apart. She reported that she tried not to use the harness during the day when Savannah would have temper tantrums. The foster mother was told that she required the Director's permission to use the harness. The guardianship worker, who had six months' experience as a worker, gave permission to continue using the harness in the interim.

The medical and Child Development Centre records indicate that the foster mother received no direction from professionals regarding the use of the harness, and that the recommended medical consultation never happened. The issue of the use of the harness was not reviewed again until after Savannah died. The Ministry's review into Savannah's death revealed that the foster mother had been using the harness since the first time Savannah had damaged the crib, likely in the spring of 1999; Savannah was placed on her stomach to sleep, and the harness confined her to the centre of her playpen and prevented her from rolling over or turning around; the foster mother thought she had been given permission to continue using the harness; and the foster mother did not recall that medical follow-up was her responsibility.

A family physician examined Savannah on September 8, 2000. He documented a delay in Savannah's growth, as she had gained only two pounds in the previous 15 months. On September 13, 2000, a psychologist at the Child Development Centre saw Savannah. He concluded that it was not possible to assess Savannah because she was too young, and recommended re-referral in a year. He was of the view that Savannah was unlikely to understand the natural consequences of her behaviour and that she should be dealt with using a "kind, behavioural approach."

On October 11, 2000, the foster mother called the Ministry and reported her "worst day ever" with Savannah. She said Savannah had been violent, screamed for hours, bit herself, threw herself on the floor, was outright defiant, and only stopped screaming when she was given ice cream.

During the fall of 2000, the foster mother reported that Savannah had bruises on her legs, face and chin from throwing herself around. She also reported that Savannah had acquired a large bruise on her head at the Child Development Centre sometime in October 2000. According to Child Development Centre policy, such an injury required a written incident report, and none was filed. Savannah's birth mother verbally reported to a Ministry worker sometime in the fall of 2000 that she, too, had noticed bruises and abrasions on Savannah's face and arms. When this issue was examined at the inquest, it was determined that the reports were made but not thoroughly documented or followed up by the Ministry.

On October 11, 2000, a pediatrician examined Savannah to assess her developmental delays. Bruises were not noted in his report; however, the pediatrician found poor growth and weight and planned further tests to determine the cause. He was of the view that Savannah had a regulatory disorder and that her behavioural difficulties could be environmental in origin. He noted that the foster mother described Savannah as having a "mean streak." The medical report was not sent to Savannah's guardianship worker until after Savannah died, three months later.

On October 16, 2000, the infant development worker conducted an assessment and determined that Savannah's global developmental delays were becoming more pronounced.

On November 24, 2000, another complaint was made by a former foster child in the home about being punished, such as being hit over the head with a wooden spoon and not being allowed to eat supper for failure to do his chores. The complaint was similar to the 1997 and 1998 allegations made by other children who had lived in the foster home. The guardianship team recommended that the complaint be investigated as part of a review of the home. The Regional Manager of Child Protection ordered an investigation. Despite the standard that required the investigation to be completed within 30 days, it was not completed until after Savannah died.

Despite an ongoing investigation, the foster home was not taken off the list of emergency home placements and, on December 29, 2000, a sibling group of six children, ranging in ages from two to nine years, was placed in the foster home. On December 30, 2000, the Acting Community Services Manager granted an exception to policy to allow 10 children in care to reside at the foster home.

During the fall and winter of 2000, Savannah was periodically absent from the Child Development Centre. For example, she attended 12 of 19 classes in November 2000; 5 of 15 classes in December 2000; and 7 of 14 classes in January 2001. Some of these absences were attributed to minor illnesses, but many had no explanation. Savannah attended the Child Development Centre for the last time on January 15, 2001.

On the evening of January 24, 2001, a 911 call was placed from the foster home, indicating that a young child in the home had hit her head on a picnic table approximately an hour before, and that she was unconscious and not breathing. The foster parents were coached through mouth-to-mouth rescue breathing while emergency personnel were routed to the home.

Savannah arrived at the Prince George Regional Hospital at 10:30 p.m. She was in a deep coma, her heart rate was slow and her core body temperature was 31.7° C (normal body temperature is 36.8° C). Extensive medical support was required to keep Savannah alive.

Savannah's foster mother reported to the treating physician that Savannah had had a mild flu-like illness for about 10 days, for which the foster mother had not sought medical treatment. She further explained the following:

- During the daytime hours of January 24, Savannah had no appetite. She fell twice, once down two carpeted stairs and once either into a pile of toys or onto the corner of a small child's play picnic table. She was not injured on either occasion.
- At approximately 5 or 6 p.m., Savannah would not eat dinner. She was given a bottle containing a mixture of formula, raw eggs and puréed banana. Savannah was placed to sleep in a playpen in a room on the main floor of the home that was warm and contained the family's covered hot tub.
- The foster mother went to check on Savannah at around 7 p.m. and found her on her stomach. Her breathing was "funny." She was making short, gasping breaths.
- The foster mother sat beside Savannah's bed and listened to Savannah's breathing for about 20 minutes. When her breathing changed from gasping to gurgling, the foster mother got scared, took Savannah into the bathroom and called 911 at approximately 8 p.m.

The hospital staff found the explanation inconsistent with Savannah's condition and notified the RCMP.

Savannah was transported from the Prince George hospital to BC Children's Hospital in Vancouver in the early morning hours of January 25, 2001. Subsequent testing found that Savannah had suffered irreversible brain damage and was "brain dead." She was removed from medical supports and died on January 26, 2001.

The initial autopsy report, dated April 30, 2001, stated that Savannah died of lymphocytic myocarditis (an inflammation of the heart tissues) or "natural causes." The coroner and the pathologist did not suspect maltreatment. The coroner was aware that the Ministry was investigating Savannah's death but did not know that there were allegations of neglect and abuse in the foster home.

In March 2002, when the coroner provided the pathologist with information about allegations of abuse in the foster home, the pathologist changed his report to include the possibility that Savannah was intentionally smothered, and changed his finding with respect to the cause of her weight loss and lack of growth. The foster mother believed that Savannah suffered from fetal alcohol syndrome although Savannah was never diagnosed by a qualified professional.

Further, in light of the information about the alleged abuse and neglect in the foster home, the pathologist determined that Savannah's weight loss and lack of growth could not be attributed to the effects of fetal alcohol syndrome and additional information suggested the child suffered non-accidental injuries. The pathologist's conclusions were as follows:

In conclusion, the documented findings in my autopsy report are unchanged but my interpretation of the findings have been modified by the new information that I received from [the coroner]. The additional information raises concerns that the child suffered non-accidental injuries and that inflicted factors, such as immersion hypothermia, may have caused or contributed to her hypoxic/ischemic brain damage. However, a potentially fatal natural condition, myocarditis, was identified at autopsy. In view of this, and absent a confession or witnessing of someone smothering the child or immersing her in cold water, I cannot unequivocally conclude that the child died from other than natural causes (Letter to Coroners Service, August 2002).

Reviews and investigations

Police investigation

The RCMP investigation immediately followed the death. Officers questioned individuals in the foster home but the home was never treated as a crime scene.

The RCMP investigation concluded in January 2002, when the pathologist found that Savannah had died of "natural causes," and before the March 2002 disclosure by Ministry staff of information about the alleged abuse and neglect in the foster home.

Although the police met with the coroner on a few occasions to discuss the autopsy report, no police investigative activities occurred between January 2002 and the fall of 2005. In the fall of 2005 and early 2006, the police conducted some additional interviews and requested new interviews with foster family members. The foster family members declined interviews. The additional police inquiries concluded in November 2007, shortly after the coroner's inquest.

Ministry reviews

After Savannah's death, the Ministry conducted an investigation of the allegations of abuse and neglect in the foster home, and also did a Director's case review.

The investigation of the allegations of abuse and neglect determined that the children were maltreated as alleged. The foster home was closed as a result of the investigation. No other foster children were placed in the home after January 2001.

The recommendations stemming from the Director's case review are discussed later in this report.

Coroners Service investigations

Savannah's death was reported to the Children's Commission in January 2001. An investigation was not completed by the Children's Commission before it was disbanded in 2002.

In May 2002, the Coroners Service Special Investigation Unit issued a report stating that Savannah's injuries were consistent with non-accidental inflicted trauma. The foster family declined to speak to the coroner and the Special Investigation Unit conducted a file review only.

In June 2003, the case was given to a second coroner for completion. The coroner interviewed the foster mother and found no new information. Other members of the foster family refused to be interviewed.

On December 10, 2004, the case was closed with an undetermined classification and with no recommendations. The coroner's report does not mention the allegations of abuse in the foster home and the closure of the foster home; however, the coroner who closed the case was aware of this information.

The Coroners Service reopened the case in the fall of 2005 in light of a request from Savannah's mother and her legal counsel. The resulting review of the case in 2005 and 2006 utilized recognized child abuse experts, and new information was uncovered through additional interviews.

In 2005, a forensic pediatrician and a pediatric cardiologist reviewed the medical records, the pathology report and a summary of the Ministry records. The pediatric cardiologist found that the mild inflammation of Savannah's heart tissue identified at the time of autopsy was not a reasonable cause of her death. Nor could this physician conclude that this condition contributed to her death. A second pediatric cardiologist, who examined the same information just prior to the November 2007 inquest, concurred. The forensic pediatrician found that Savannah was most likely intentionally smothered.

In December 2007, the Coroners Service attributed delays in completing the investigation into Savannah's death to the police investigation and a personal crisis in the foster family.

Coroner's inquest

A coroner's inquest was called in January 2007 and occurred between October 22 and November 3, 2007. The coroner's jury classified Savannah's death as a homicide. The jury submitted 17 recommendations with respect to Ministry practice, as well as recommendations for the Ministry of Health, the College of Physicians and Surgeons, the City of Prince George Fire Department and the B.C. Ambulance Service. These recommendations are included in Appendix E.



5. Rowen Von Niederhausern

Rowen Von Niederhausern was born on June 4, 2001. His mother had ongoing medical problems, and his parents had difficulty managing the family and the home. The Ministry was involved with the family before Rowen's birth, and starting again when Rowen was one year old. Rowen died as result of swelling in his brain on August 16, 2002, at the age of 14 months. A coroner's inquest classified his death as accidental. There were no criminal proceedings.

Rowen's mother had contact with the Ministry during her childhood. She had been severely abused as a child and, according to her physician, suffered long-term problems as a result of the abuse and neglect.

Rowen had two older siblings who were removed from their mother's care at a young age and adopted. They had been abused and suffered serious physical injuries. A close family member was convicted of the crime and served two years probation.

In September 1999, when Rowen's mother was with a new partner, she gave birth to her third child, Rowen's older sibling. A member of the hospital's nursing staff contacted the Ministry because she knew of the mother's family history. The Ministry instructed hospital staff not to discharge the infant from hospital without notifying the Ministry. Rowen's sibling went home with his parents prior to the Ministry receiving notification. When the Ministry was informed that the infant had been discharged, a child protection social worker attended the home and removed the child.

On December 16, 1999, after intensive psychological and medical evaluations and parental capacity assessments were completed, the child was returned to his parents' care under a supervision order that required frequent (daily at first) visits by the Ministry staff until the child was "fully mobile."

A parental capacity assessment: An assessment requested by the Ministry to determine a parent's ability to meet the needs of his or her child or children. It is performed by a psychologist or psychiatrist. There are no practice standards as to how this type of assessment is performed.

The family was provided with a teaching homemaker to assist them in developing parenting skills. A public health nurse visited the home weekly until February 2000.

The return of the child was conditional on his mother continuing to see a counsellor, his parents' participation in parenting courses, and no unsupervised access by the relative convicted of child abuse. According to the Ministry file, the parents abided by the conditions.

The parental capacity assessment noted that because of the parents' personality types, they might not recognize problems, or could deny or minimize the existence of problems in order to appear competent as parents. These tendencies were noted as having the potential to become serious should "outside stresses stretch their ability to cope." The parents were assessed as presenting "complex child protection and treatment issues" but capable of identifying the need for help with their children. The assessment indicated the mother had made gains in her ability to parent.

In February 2001, Ministry staff made an assessment as to whether services for the family could be discontinued. The supervisor directed the worker to complete a comprehensive risk assessment before closing the file, and to interview the parents and "collaterals" (other individuals, such as the family physician, the homemaker and other family members) to determine how the family was managing and whether they were able to safely care for a young child.

However, the file was closed in February 2001 without completion of these interviews. The worker reported that an assessment had been completed, but it appears that the supervisor did not ensure that the instructions about the interviews were followed. The worker concluded that the factors that had put the child at risk were no longer present. Rowen's mother was approximately six months pregnant with him at the time the file was closed. The Ministry was not aware of the pregnancy.

Rowen was born on June 4, 2001, the second child born to his parents, and the fourth child born to his mother. Rowen's mother was 27 years old at the time of his birth. The hospital did not notify the Ministry of Rowen's birth. The fact that the Ministry had previously asked that the older sibling not be discharged without notification had not been formally noted by the hospital at the time.

On June 11, 2002, when Rowen was one year old, the Ministry had its first contact with the family since the family service file had been closed. A community member reported hearing an infant screaming and believed no one was attending to the baby. The older child had been observed dangling out of a window of the family's mobile home and another time, playing near an unattended barbeque. The child protection worker consulted with her supervisor about the report. During this consultation, the worker learned of the history of the family's contact with the Ministry and the significant past concerns for the safety of the children.

The worker attended the home unannounced the day after the report was received. She found the parents sitting outside and the children sleeping together on the sofa in the living

room. Shortly after she arrived, smoke from an unattended pot on the stove filled the home. The worker was at the residence for about an hour, and most of that time was spent helping the family evacuate the children and clear the smoke from the home. She found that they needed to install smoke detectors. The home was "messy" and the family had many cats.

The worker learned that the mother had health problems and frequently spent the day in bed, and that the family was struggling financially. The father was the family's sole financial support and, as a result of the mother's health problems, was the children's primary caregiver.

The parents told the worker that they believed they were managing well and would ask a relative for help if they needed it. The worker left the home after directing the family to install some smoke detectors, to move the sofa so the older child could not get out of the window, and to ensure the safe use of the barbeque.

The worker followed up three weeks later. She noted that the home was in a messy state. She contacted the public health nurse and found out that Rowen was a little behind in his vaccinations. She also learned that the father had visited the health unit in February 2002 complaining of depression, exhaustion and "not being able to cope." He also had narcolepsy and took medication for this condition.

Rowen's mother had been having severe headaches and had possibly suffered a small stroke, resulting in some mobility problems. She spent entire days in bed and did not participate in much of the children's care. The family doctor was not contacted by the Ministry to provide a more detailed picture of the mother's health problems.

The family had the support of a relative who would occasionally help with the children, but the relative would not go into the family's home because she was allergic to cats. Another close relative was often at the home to help clean. This relative was the one who had been convicted of child abuse and was not supposed to have unsupervised access to the children.

On July 15, 2002, the worker returned to the home to review the home environment and found that her recommendations, including installation of smoke detectors, raising the barbecue off the ground and moving the furniture to ensure the children's safety, had been implemented. She spoke briefly with the parents and found them open to suggestions and co-operative. The father denied any use of drugs. The worker was of the view that, compared to the other families on her caseload, this family was coping well. She did not feel that they were in crisis. The worker closed the file on July 16, 2002, without consulting her supervisor. The children were found not to be in need of protection.

According to Rowen's father, in the early morning hours of August 16, 2002, he was trying to get Rowen to sleep. They were settled in a recliner in the living room. Rowen fell asleep on his father's chest. During the night, Rowen's father awoke and discovered that urine from Rowen's wet diaper had leaked onto his chest. Rowen's father changed and fed him

and they both went back to sleep. At approximately 9 a.m., the older child woke up and needed attention. Rowen was placed to sleep on his back on the sofa and his father went to prepare a bath for his older sibling. The father believed something was wrong and went back out to the living room to find that Rowen was not breathing and did not have a pulse. He called an ambulance, and was coached by the 911 operator in performing CPR.

Rowen was transported to the hospital. He was pronounced dead approximately an hour after he was admitted to hospital.

The autopsy was completed on August 17, 2002. The cause of death was diffuse cerebra edema (swelling of the brain). The pathologist concluded that Rowen did not die from a natural disease process and that he was not smothered, but that there was a possibility that he had been shaken. The findings were forwarded to the RCMP.

Reviews and investigations

Police investigation

The RCMP concluded its investigation in October 2005 and the file was closed. The case was presented to Crown counsel but charges were not approved.

Ministry review

The Ministry conducted a Deputy Director's review (a review of file material only) a year after Rowen died. The Ministry staff attributed the year-long delay in completing the review to the ongoing criminal investigation. The recommendations that resulted from the review are discussed later in this report.

Coroners Service investigations

Rowen's death was investigated by the coroner. In early 2006, the Coroners Service consulted with an expert on child abuse from the United States. The expert concluded that Rowen's death was a result of an episode of violent shaking. The expert found that the autopsy was incomplete and suggested changes to the autopsy protocols for suspicious child deaths, including a skeletal survey and, in cases where it is suspected that the child was shaken, more complete examination of the brain, spinal cord and eyes.

The changes were adopted by the Coroners Service. The expert's opinion on the cause of Rowen's death was forwarded to the RCMP. No new action was taken by the police.

Coroner's inquest

An inquest into Rowen's death was called in late 2006. The inquest was conducted approximately six months later and concluded on June 20, 2007. The coroner's jury found that the death was accidental. The jury's recommendations are included in Appendix E.



6. Serena Wiebe (John)

Serena Wiebe was born on November 22, 2004. Serena was a First Nations child. Serena's mother struggled with alcohol and drug addictions. Serena had three older siblings who had been removed from her mother's care before she was born. She died during the night, apparently in her sleep, on June 17, 2005. She was almost seven months old at the time of her death. A coroner's inquest in October 2007 classified her death as undetermined.

Serena Wiebe's mother is a member of the Yekooche Band, in the Fort St. James area, which is represented by Carrier Sekani Family Services. She struggled with alcohol and drug addictions for much of her adult life. Serena's mother had her first contact with the Ministry in March 1996, when she was 18 years of age and her first child was three weeks old. Ministry staff provided Serena's mother and her infant with services. A second child was born in 1998 and a third in 2000.

Between 1997 and 2000, the Ministry received three reports that the children were being neglected.

In May 2000, after the birth of the third child, the Ministry completed a comprehensive risk assessment. The children were found to be at risk for harm if left in their mother's care. A supervision order was put in place for six months. The children went to live with a relative as one of the conditions of the supervision order, and Serena's mother was asked to participate in drug and alcohol counselling.

Serena's mother was unable to meet the conditions for retaining custody of her children. In September 2000, a family member was granted permanent custody of the sibling group. Serena's mother maintained contact with her children. Serena's mother had no further contact with the Ministry until May 2, 2005.

Serena Wiebe was born on November 22, 2004, her mother's fourth child, but the first child born to her mother and a new partner. The person who made the report to the Ministry reported that Serena's mother and her new partner were drinking and smoking crack cocaine while caring for five-month-old Serena. The report was accepted for investigation in Prince George and the file was transferred to Fort St. James for "further assessment." The information was relayed not as part of an open child protection file but as part of a file transfer.

When the information was received in Fort St James from the Prince George office it was marked "for assessment only" so the worker decided to assess it as soon as possible. The worker found it difficult to locate the parents because they moved frequently and didn't have a phone. Serena's family was located living off-reserve near Fort St James.

The worker contacted a representative of the Yekooche Band's community-based response team who was also Serena's mother's paternal aunt. She was a member of a team that works closely with the ministry social workers concerning the welfare of children in its community. Volunteer members from the response team accompany ministry social workers whenever they are called out to community members' homes.

These two individuals visited Serena's family. They were also accompanied by a worker from Nezul Be Hunuyeh Child and Family Services. The visit was unannounced; the family had no prior knowledge of it.

Carrier Sekani Family Services

Carrier Sekani Family Services had Level 13 (currently known as Category 4, or otherwise Guardianship) delegation in 2005 and currently has the same level of delegation. The Aboriginal Operational and Practice Standards and Indicators (AOPSI) identifies Guardianship services as a unique level of delegation with respect to the ongoing management and care of children and youth in continuing care: this is in addition to Voluntary Services delegation that includes provision of voluntary agreements and the recruitment, support and retention of family care homes.

Nezul Be Hunuyeh Child and Family Services

Nezul Be Hunuyeh Child and Family Services Society signed an initial agreement with the Province in July 2002 to commence the delegation enabling process. The Agency was not operational for the delivery of delegated services in 2005.

When the workers met with the family, Serena appeared healthy and the parents were not under the influence of drugs or alcohol. The home was clean. The mother stated that she and the father were getting along well and that she was working hard to maintain a healthier lifestyle. She stated that she did not have any health problems and that she was not using drugs. The question of where the baby slept was raised. The record is unclear about the response provided by Serena's mother. One worker recalls that the mother said Serena slept "in our room down the hall," and that the bedroom was not explored for

appropriateness or safety. Another worker remembers that Serena's mother said she slept on the couch, and that she did not know if the mother meant that they had slept on the couch the previous night or that they slept there routinely. The workers learned that the couple took turns going out and if they were going to be drinking they had relatives who would care for the child.

The representative from the community-based response team told the ministry social worker that there was an informal safety plan among family members in place for Serena. She stated that family members visited Serena's mother as a way of monitoring the family. She stated that they would watch over the infant if they knew or suspected that her parents were drinking.

The ministry worker did not attempt to access any medical information about the mother because she did not have reason to do so. She observed that Serena looked healthy and well cared for, and she saw no evidence of drug use in the home. The worker confirmed that the infant was receiving routine medical care. The worker's supervisor stated that medical information was difficult to obtain from local doctors because they may feel bound by confidentiality provisions not to release information.

After a discussion with the supervisor, the ministry social worker submitted the file for closure with a finding that the child was not in need of protection. The worker believed that the Band's representative from the community-based response team would assist in monitoring the family, and no formal safety plan was laid out. She reported carrying a very high caseload as a result of chronic shortages of staff in Fort St James.

According to the coroner's report, in the days before she died, Serena had been ill with a mild flu-like illness. She had no history of any health problems. During the evening hours of June 16, 2005, Serena was placed to sleep with her mother on the sofa. Serena's mother had consumed some alcohol during the daytime hours and took a prescribed sedative before going to sleep. Serena died sometime during the night.

The autopsy was performed on June 20, 2005. No injuries were identified. The pathologist identified evidence of mild viral infection which may or may not have contributed to her death.

Reviews and investigations

Police investigation

The police concluded their investigation shortly after Serena died. There was no evidence to suggest that Serena's death was related to abuse or neglect. No charges were laid.

Ministry review

The Deputy Director's review of this case was completed 11 months after the death. The review generated four recommendations, which are discussed later in this report.

Coroners Service investigations

A coroner's inquest into the death of Serena was called in February 2007. The two-year delay was caused in part by the Coroners Service file management in the region. Coroners files were not effectively tracked for completion within the four-and-a-half-month time frame prescribed by Coroners Service policy. The Coroners Service attributes additional delays to the need to wait for Ministry staff to complete their review and implement any recommendations made as a result of the review. The regional coroner wanted to wait to make a decision about taking this case to inquest until the recommendations from the Ministry review were implemented.

There is no indication as to how the implementation of the recommendations affected the coroner's decision-making process regarding the conclusion of the case. The police investigation was not a factor in the delay, because there was no evidence to suggest that Serena's death was related to abuse or neglect and the police investigation was completed shortly after Serena's death.

Coroner's inquest

The inquest was completed on October 12, 2007. The coroner's jury classified Serena's death as undetermined, a classification consistent with sudden, unexpected infant deaths like Serena's.

The coroner's jury made nine recommendations to the Ministry, which are included in Appendix D.