CORONER'S COURT OF BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 22 October, 2007 at Prince George, British Columbia, and continued on the following dates Thru November 3, 2007 into the death of HALL, Savannah Brianna Marie find he/she came to his/her death at approximately 1750 hours on the 26th day of January, AD, 2001 at or near Vancouver ,British Columbia

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) Hypoxic Ischemic Brain Injury

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Cerebral Edema

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c) Suffocation

(2) Other Significant Conditions Contributing to Death:

CLASSIFICATION OF THE EVENT ☐ ACCIDENTAL ☒ HOMICIDE ☐ NATURAL ☐ SUICIDE ☐ UNDETERMINED

The above verdict certified by the Jury on the 3rd day of November AD, 2007.

SCOTT FLEMING

Presiding Coroner's Printed Name

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age:	3 years	Gender:	☐ Male	☒ Female	
Date of Birth:	9 September, 1997	Native:	☒ Yes	☐ No	
Coroner's Case No.:	2001:609:0005	Post Mortem:	☒ Full	☐ External	☐ None
Police File No.:	01-2206	Toxicology:	☒ Yes	☐ No	
Police Department:	Prince George RCMP	Identification Method:	☒ Visual	☐ Other	(specify below)
Court Reporter:	Alanna Siemens	Identified by:	Family		
Phone:	250-561-0048	Premise of Injury:	Residence		
		Premise of Death:	Hospital		

BRITISH COLUMBIA

CORONER'S COURT OF BRITISH COLUMBIA

held at **Prince George** , British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

HALL	Savannah Brianna Marie
SURNAME	GIVEN NAMES

INTRODUCTION

This Inquest into the death of HALL, Savannah Brianna Marie commenced at 0900 hours on October 22, 2007, at the British Columbia Supreme Court, Courtroom 104, Prince George, BC, and continued through November 3rd, 2007. Mr. Christopher Godwin was counsel to the Coroner.

Counsel appearances were as follows: Mr. Doug Eastwood and Ms. Mailyne Ouellet, representing Her Majesty the Queen, as represented by the Ministry of Children and Family Development; Mr. Peter Grant and Mr. Michael Ross, representing Corinna Hall; Mr. Brian Gilson, representing Mrs. Patricia Keene; Mr. Richard Gibbs Q.C., representing Mr. Richard King and Mr. Andrew Kemp, representing the Attorney General of Canada, as represented by the RCMP.

Deputy Sheriff Brett Hickey took charge of the jury and recorded the entry of two Exhibit Volumes, comprising a total of 63 documents, into evidence.

The following witnesses testified:

1. Peter Cunningham
2. Dr. Glenn Taylor
3. Corinna Hall
4. Scott Horvath
5. Dr. Marie Hay
6. Dr. Robert Reece
7. Anita Bassett
8. Candis Johnson
9. Iris von Sychowski
10. Philip Turgeon
11. Arlene Goddard
12. Georgie Gerula
13. Richard King
14. Dr. Jean Hlady
15. Katrina Ludwig
16. Robert Watts
17. Chase Keene
18. Candace Keene
19. Deborah Freake
20. Patricia Keene

21. Dr. Simon Earl
22. Blake King
23. Paul Peterson
24. Tim Archer
25. Sgt. Heidi Wild
26. Dr. Ken Poskitt
27. Jennifer Heppner

PRESIDING CORONER'S COMMENTS

The following is a brief synopsis of the facts and issues reviewed during the inquest. The purpose of these comments is to assist the reader to more fully understand the Verdict and Recommendations of the jury. It is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

Savannah was a three year old girl who died in hospital on January 26, 2001 after being found unresponsive in her crib by her foster mother on January 24, 2001. Savannah was born to her 18 year old mother, a member of the Lake Babine Nation, on September 9, 1997. Savannah's mother had a long history with the Ministry of Children and Family Development ("MCFD"), and had herself been a permanent ward of the MCFD at one time during her childhood years.

Shortly after birth, Savannah was removed from the care of her mother. A long history of removals, Interim Orders, Voluntary Care Agreements, placements and Supervision Orders by the MCFD culminated in Savannah's final removal from her mother on May 27, 1998. Savannah was then placed into permanent foster care at the Keene home on September 29, 1998. During her short life, Savannah's MCFD case file was transferred six times amongst various child case workers.

Savannah remained in the care of the Keene family until her death. During this time she participated in a number of MCFD resource programs including the Infant Development Program ("IDP") and the Childhood Development Centre ("CDC"). She underwent a number of medical assessments and was seen by a pediatrician on two occasions.

In the days preceding January 24, 2001 Savannah had been kept home from her daycare program at CDC as she had reportedly been unwell. After a few minor falls earlier in the day on January 24, 2001, Savannah refused her evening meal and was put to bed in her crib with a bottle. A few hours later Mrs. Keene noted that Savannah was having difficulty breathing.

After sitting with her for another 15-20 minutes and observing her condition, Savannah's breathing sounds became worrisome and an emergency call to 911 was made. Savannah was admitted to Prince George Regional Hospital ("PGRH") in grave condition, and was subsequently transferred by air ambulance to B.C. Children's Hospital ("BCCH") in Vancouver where she later died on January 26, 2001.

Peter Cunningham, Executive Director of the Northern Region of the MCFD, described the structure of the MCFD during the time period immediately preceding the death of Savannah. He identified the three main service teams of social workers at the MCFD office in Prince George that were involved in Savannah's care, and their respective areas of responsibility. Mr. Cunningham introduced the jury for the first time to the events which took place in August 2000 when an MCFD social worker discovered that a restraining harness was being used to keep Savannah in her crib in order to deal with her reported "night terrors". He detailed the MCFD response to this discovery, and the major shortcomings of the MCFD investigation into this significant care issue. Mr. Cunningham also described the significant "staffing challenges" which the Northern Region of MCFD was dealing with during the relevant period of time.

Dr. Glenn Taylor, a consultant pediatric pathologist from BCCH, described the results of his autopsy findings. He described his initial conclusions as to the cause of death, and the process by which he later concluded that the cause of death was Hypoxic/Ischemic Brain Injury of undetermined cause. He discussed the significance of his finding of the presence of lymphocytic myocarditis, and the role which it might have played in Savannah's death. Although initially Dr. Taylor concluded that the lymphocytic myocarditis led to a cardiac arrhythmia, which in turn resulted in the hypoxic event and brain injury, after reviewing additional evidence he was unable to determine what caused the hypoxic event, and concluded that it was of undetermined origin.

Dr. Taylor noted the various external traumatic marks which he found on Savannah's body, many of which he found particularly concerning. He described other findings, from both the documented medical findings and his autopsy examination, which he found particularly concerning. These included: the significant cerebral edema noted on CT examination; the low body temperature (hypothermia) found on admission to PGRH; the extremely decreased level of consciousness upon admission; the metabolic imbalance of low levels of sodium and potassium which were noted on admission to PGRH.

The birth mother Corinna Hall testified as to the events in her life leading up to Savannah's birth, and the course of her dealings with MCFD social workers and other care providers in the years preceding Savannah's death. She described her recollection of the various MCFD interventions which took place prior to Savannah coming into the permanent care of the MCFD. She described her visits with Savannah after she had been placed in the Keene foster home in September 1998. Ms. Hall testified as to her observation of concerning bruising on Savannah during scheduled visits, and the steps which she took to bring this to the attention of various social workers. Finally, she described her recollection of the events of her last visit with Savannah prior to her death.

Scott Horvath, a Team Leader with the Family Services Team at the MCFD, testified as to his team's role in managing Savannah's care, as well as several significant events in which he was a major participant. These included: the voluntary care plan of February 1998; the third and final removal of Savannah which occurred on May 27, 1998; the harnessing issue identified by social worker Deborah German on August 16, 2000. He described the MCFD document "Child Services Case Snapshot" dated January 19, 2001 which set out the placement history for Savannah, as well as the legal authority under which the MCFD acted in making the various placements. Mr. Horvath testified that he was not aware of the then current MCFD Document "Standards for Foster Homes (1998)", or the fact that the MCFD had in place any standards governing the use of physical restraints in foster homes. He was not aware of any training having been given to social workers in respect to the use of physical restraints. Mr. Horvath also spoke of some of the significant challenges which the Northern Region was facing at the time which included: the introduction of new technology; the introduction of new child welfare standards; significant staffing shortages; high social worker caseload levels. As a result of these challenges, Mr. Horvath testified that his team faced significant difficulties in keeping up with their job responsibilities. In response to a question from the jury Mr. Horvath testified that he was not aware of whether there were any medical First Aid standards required of foster parents.

Dr. Marie Hay was the attending pediatrician at PGRH responsible for Savannah's care from first admission on January 24, 2001 at 2023 hours, until transfer to BCCH in Vancouver the following afternoon. Dr. Hay described her medical examination and findings, as well as the treatment provided to Savannah during her admission at PGRH.

Dr. Hay testified as to her significant concerns surrounding several of her findings including: the contents of Savannah's bottle and her unattended placement into the her crib with the bottle; the possibility of Savannah having aspirated; the hypothermic condition of Savannah on admission to PGRH; her low level of consciousness; areas of unexplained and worrisome bruising; electrolyte imbalance; significant cerebral edema. Dr. Hay stated that based upon the history provided by Ms. Keene, she was unable to reconcile several of her clinical findings such as the hypothermia, the degree of cerebral edema (brain swelling), the chemical imbalance (low sodium) and finally, the worrisome bruising. Dr. Hay advanced a theory which she had recently read in a British Medical Journal ("BMJ") article which, in her view, explained these inconsistencies. She acknowledged that this was simply a "theory", but one which in her mind reconciled her concerns about the inconsistencies presented by this case.

Dr. Robert Reece provided the jury with his expert opinion as to the cause of Savannah's death based upon his review of the investigative findings and medical reports which had been provided to him. Dr. Reece is an internationally recognized pediatric clinician and professor at Tufts University in Boston, with a specific expertise in child abuse. He testified that the medical cause of death was a hypoxic/ischemic event with resultant hypoxic encephalopathy. In his opinion, the significant clinical findings of hypothermia and metabolic imbalance resulted from the cerebral edema, and were not the cause of the condition.

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Dr. Reece testified that the lymphocytic myocarditis was not a causal factor in Savannah's death. He similarly rejected the theory advanced in the BMJ article and found it inapplicable to Savannah's death. Although Dr. Reece was unable to identify the exact suffocation event which resulted in the hypoxic encephalopathy, he testified that the event was either an intentionally inflicted manual suffocation by the placement of something like a pillow over the mouth and nose of the child, or alternatively, an aspiration of the bottle or stomach contents. The possibility of an intentionally inflicted manual suffocation was supported by several worrisome findings which Dr. Reece described as being the following: the location of bruises found on Savannah's body; the various time delays that were provided by the foster mother to the attending clinicians at PGRH; the presence of frank blood reported by the mother to have come from Savannah's nose during the initial resuscitation attempts; the evidence which he reviewed concerning allegations of inappropriate care in the foster home such as cold showers, and the use of wholly inappropriate physical discipline and restraint methods. Dr. Reece concluded by stating that in his expert opinion, the "context for abuse" was present in this case, and that Savannah's death was preventable.

Anita Bassett testified as to her role in Savannah's care from April 21, 1998 until September 30, 1999 as a member of the Family Services Team that reported to Mr. Horvath. She discussed the various referrals that she made for Savannah, as well as the frustrations which she experienced in accessing all of the resources which she thought would be helpful to Savannah due to governmental rules, regulations and standards. Ms. Bassett testified that upon placing a child into care she tries to provide the foster family with as much medical information as is available at the time of placement. She testified as to her discussion in June 1999 with the foster parent about Savannah's night terrors, and how they were being dealt with. She had no knowledge that the restraining harness was being used by the foster parents until after Savannah's death. She was not aware of any previous complaints surrounding the care provided by the Keene foster home, nor was she ever aware of bruising having been observed on Savannah's body. In response to a question from the Presiding Coroner, Ms. Bassett testified as to her concern that there was insufficient liaison and information sharing between the resource worker (who would be aware of concerns about the foster home), and herself as guardian for Savannah.

Candis Johnson, an early childhood educator with the CDC, described the various programs provided by CDC, and Savannah's progress in the program during the period September 1999 until September 2000. Another CDC worker, Iris von Sychowski, had been responsible for Savannah from April 1999 until September 1999 and then once again from September 2000, until the time of Savannah's death on January 26, 2001. Ms. Johnson testified that Savannah had developmental delays in several areas, but that during the course of her time at CDC, definite improvements were noted. In particular, Savannah's tantrums had decreased significantly in their frequency. Ms. Johnson testified that she never saw any worrisome bruises on Savannah's body, nor did she ever have any concerns about the Keene foster home based upon her observation of Savannah's interactions with the family members.

Ms. Johnson did, however, express surprise that Savannah only saw the pediatrician, Dr. Simon Earl, on two occasions during her life and assumed that she had been seeing him more frequently.

Iris von Sychowski was also an early childhood educator with CDC, and was responsible for Savannah's care while at the program for the four months immediately preceding her death. Savannah's attendance record at the CDC daycare program was reviewed. Significant absences from the program were recorded for the last five months of Savannah's life. Both Ms. von Sychowski and Ms. Johnson described the absences as being potentially worrying. They both testified that the uncharacteristic absences would have been investigated further had the trend continued. Ms.von Sychowski testified about some bruising which she observed on January 15, 2001, the last day that Savannah was at CDC prior to her death, and the steps which she took to follow-up on her concerns with her supervisor and the MCFD social worker. Ms. von Sychowski testified that during her dealings with Savannah she never had any concern about the care being provided in the foster home.

Mr. Philip Turgeon was the Resource Team social worker responsible for the Keene foster home during the majority of the time that Savannah was placed in that home. He provided a general overview of the various levels of foster homes, and the methods used by the MCFD in managing these resources. Mr. Turgeon testified that at various times the Keene home had more children under care in the home than was allowed by MCFD policy. In particular, he described a chance meeting with Mrs. Keene in December 2000 which caused him to raise an alarm with other social workers at the MCFD. Mr. Turgeon testified that as a result of that meeting he learned that Mrs. Keene had recently received an additional six foster children into her home, one month after it had been determined that the home was to undergo a Protocol investigation as a result of recent allegations about past abuse. An exchange of emails took place between various MCFD social workers following this information being provided by Mr. Turgeon. Mr. Turgeon testified about the August 2000 discovery of the restraint harness in the Keene home, and the investigations which followed. At that time Mr. Turgeon was aware of the MCFD document "Standards for Foster Homes (1998)". It was his understanding that these standards only authorized the use of physical restraints on children in MCFD care in "crisis" situations, and only after specialized training and prior approval for their use had been obtained from the MCFD. Mr. Turgeon also testified about his involvement in investigating allegations of improper discipline being used against children in the Keene home in 1997 and 1998.

Arlene Goddard was a social worker with the Family Services Team led by Scott Horvath. She was responsible for the care of Savannah from April 2000 until she was transferred to the care of the Guardianship Team in October, 2000. Ms. Goddard was the social worker that was most closely involved in the investigation of the use of the restraint harness on Savannah in August 2000, and her subsequent decision to temporarily approve the continued use of it pending confirmation of medical approval.

She described the steps taken to conduct this follow-up, and the fact that the MCFD ultimately relied upon Mrs. Keene's own advice that the necessary medical approval had been obtained, without any independent confirmation of this important fact having been made by the MCFD. It was determined after Savannah's death that no medical approval had been sought or obtained for the use of the harness.

Georgie Gerula worked as both a team leader in the Resources Team, and then later as a member of the Guardianship Team. She described her role in the investigation of the 1998 allegations of inappropriate child discipline in the Keene home involving mouths being washed out with soap, the use of forced cold showers, and children being locked in their rooms. Once she learned that these allegations followed on similar ones made a year earlier, Ms. Gerula testified that she wished to have these most recent allegations investigated more formally. However, MCFD management directed that these investigations be conducted more informally, resulting in Mr. Turgeon's brief discussion of the allegations with Ms. Keene, and the subsequent decision that they were unsubstantiated. No independent review of these allegations was ever conducted by an MCFD social worker who was not involved as a social worker for either the foster home or the child in care. Ms. Gerula testified that after Savannah was transferred to the Guardianship Team in October 2000, there were no visits to the Keene home by a member of that team prior to Savannah's death, notwithstanding the fact that the use of a restraint harness on Savannah had been noted in the Plan of Care completed at the time of Savannah's transfer. Upon learning in November 2000 that a Protocol investigation of the Keene home had been called as a result of recent allegations of abuse, Ms. Gerula testified that she then became concerned about the potential for abuse in the home.

Richard King was the Regional Child Protection Manager during the period of Savannah's involvement with the MCFD. He provided an overview of the operation of the child protection system in the Northern Region, and how it interacted with the front line social workers from the various MCFD teams. Levels of authority and responsibility were reviewed. His first involvement with Savannah arose in August 2000 as a result of the discovery of the restraint harness in the Keene foster home. He discussed his role in that investigation, as well as his expectations as to how that investigation would be conducted by the front line social workers. Mr. King's knowledge of the Keene home dated back to 1991 when he first placed a child into that home. He described the Keene home as being a well regarded resource, and he personally held the Keene foster parents in high regard. He testified as to his involvement in the events which gave rise to the decision to launch a Protocol investigation of the Keene home in November 2000 as a result of recent allegations regarding possible abuse in the home. Mr. King testified as to his concern that this investigation started only after the events immediately preceding Savannah's death had occurred. Once the Protocol investigation was completed in approximately May 2001, Mr. King testified that it was only then that he was able to see the "big picture" of a pattern of abuse or maltreatment in the Keene home which ultimately led to the MCFD decision to remove the children in care, and close the home to any future placements. Mr. King discussed the circumstances which resulted in six additional children being placed in the Keene foster home on an emergent basis on December 28, 2000.

This placement did not come to Mr. King's attention before it occurred, but if it had, he would not have approved it. Mr. King was at a loss to explain how this placement could have occurred given that the Keene home was the subject of a Protocol investigation. It appeared to him that the Keene home had not been removed from the list of available resources which was used by the after-hours night intake social worker. Mr. King testified about a number of factors which, in his opinion, resulted in two missed opportunities to have the Keene home investigated, and ultimately shut down. These factors included a lack of available resources, the fact that the types of allegations being made were somewhat "new" to all of the social workers, and finally, the level of trust and respect which the Keene's enjoyed within the MCFD and fostering community.

Dr. Jean Hlady testified as an expert pediatrician, with extensive experience and expertise in the investigation of child abuse cases. Dr. Hlady was the physician who was responsible for the care of Savannah during her short stay at BCCH immediately prior to her death. Dr. Hlady testified that although some of the bruises which she observed on Savannah were "concerning", she was unable to conclude that they were "definitely inflicted". She was, however, concerned that her physical findings based upon her examination of Savannah simply did not "fit" the history which had been provided to her. Of particular concern was Savannah's low body temperature, the low sodium levels and the massive cerebral edema found on the CT scans.

The expert reports of Drs. Chang, Sandor and Patterson were read into evidence. Dr. Chang was the Emergency physician at PGRH who initially examined Savannah upon her arrival, and then transferred care to Dr. Marie Hay. Drs. Sandor and Patterson are expert pediatric cardiologists who each opined that the observed lymphocytic myocarditis found on autopsy was not a causal factor in Savannah's death.

The statement of Child C (sometimes referred to as Child 46) was read into evidence. It was this evidence that led to the November 2000 decision by the MCFD to conduct a Protocol investigation of the Keene home. However this investigation was not actually commenced until after Savannah had been admitted to hospital on January 24, 2001.

Katrina Ludwig was a social worker assigned to the Intake Team at the Prince George office of the MCFD. Ms. Ludwig described the three types of Protocol investigations conducted by the MCFD. She testified as to the circumstances leading up to her January 25, 2001 assignment to conduct a Protocol investigation of the Keene foster home. These circumstances included Savannah's hospitalization the day previous, as well as the allegations of potential abuse which had been made in November 2000 by a child who had once been in care at the Keene home. Ms. Ludwig had first been contacted about her availability to conduct this Protocol investigation during the last week in November 2000, but was unable to assist at that time due to other work commitments. However, it was not until after she had begun her investigations in late January 2001 that she learned that the investigation she was now conducting was in fact the same Protocol investigation from November 2000 which had not yet been assigned. Ms. Ludwig described her interview with Child "MB", and the transcribed tape of the interview was entered into evidence.

Ms. Ludwig determined during the course of her investigations that there had been six earlier reports of concern involving the Keene home. Ms. Ludwig also testified that she was the Intake Team social worker who temporarily placed six children in the Keene home at the end of December 2000. At that time she was not aware that a Protocol investigation into the Keene home had been called. She testified that had she known this fact she would not have placed these six children into the Keene home.

Robert Watts is the designated Director of Child Welfare for the Northern Region of the MCFD. Mr. Watts described the current management structure of the MCFD, and compared it to the structure which existed during the period 1997-2000. He described the initiatives of the MCFD which had resulted in the "regionalization" of child welfare and quality assurance functions, and the anticipated improvements which these changes would bring to the child protection function of the MCFD. He described many of the new MCFD initiatives which are directed at responding to the difficulties they were experiencing in attracting and retaining qualified social workers in the Northern Region. Mr. Watts also described the enhanced ability of the MCFD to both document and track more aspects of the work done by MCFD social workers, and the limitations inherent in the system as presently implemented. In particular, Mr. Watts testified that the concerns expressed by Mr. King about the inability of the MCFD to "pull together" various allegations relating to care provided in foster homes had not been completely addressed by the present MCFD tracking system. This is because the system only tracks confirmed findings of abuse and/or neglect in the resource home, whereas other unconfirmed allegations would simply be added into the resource file and then hopefully noted during the annual review of the foster home. Mr. Watts agreed that the ability to track all allegations made about care in a foster home, whether substantiated or not, would be a useful addition to the tracking capability of the system currently used by the MCFD.

Chase Keene, one of Mrs. Patricia Keene's two natural daughters, testified as to Savannah's care in the family home during the time of her placement, as well as her recollection of the events of January 24, 2001. She testified that the restraint harness was used only "occasionally" and certainly not every night. She testified that she never witnessed any inappropriate discipline being directed towards Savannah. She assumed that her mother had received the necessary approvals to use the restraining harness to deal with Savannah's night terrors. Chase was not at home at the time Savannah was found in medical distress, but returned soon after to the family home once notified of the event. Her recollection of the events of that evening was extremely limited.

Candace Keene is also a natural daughter of Mrs. Patricia Keene. She was living at home, and was present during the events which took place in the Keene home on January 24, 2001 and the days immediately preceding that evening. She testified that she had absolutely no recollection of any events which occurred during the period starting in late December 2000 up until the time of Savannah's memorial service due to a subsequently diagnosed mental condition known as "conversion disorder". Candace did however provide a statement to Ms. Katrina Ludwig, the MCFD social worker who conducted the Protocol Investigation, on January 26, 2001, a copy of which was entered into evidence.

Deborah Freake was the part time housekeeper for the Keene family from 1997 until just after Savannah's death. She described her observations of Savannah during the times that she saw her in the Keene home. Ms. Freake testified that she never saw a restraint harness in the home. She testified that she observed Savannah's tantrums. She never observed any concerning bruises on Savannah's body. Ms. Freake testified that the interactions which she observed between Mrs. Keene and the foster children in her care appeared quite normal, and she never saw anything in the home which caused her concern.

Mrs. Patricia Keene described her involvement as a foster parent to Savannah from the time that she was first placed in her home in September 1998, until the time of Savannah's death. Mrs. Keene testified as to her long history as a foster parent for the MCFD, and reviewed an MCFD document detailing the history of placement of foster children in the Keene home. She described her dealings with the several social workers who were responsible for managing Savannah's care. She described Savannah's level of development at the time she was first put into her care, and the concerns which she had about her progress and developmental delay during her time with the Keene family. Mrs. Keene testified about the various medical and care resources which were available to Savannah and the steps which she took to see that Savannah was able to gain access to them. She testified that she used the restraint harness on Savannah for sleeping on no more than 12 occasions, but did use it more frequently on both Savannah, and other small children, while they were in the high chair in order to keep them safely secured. Mrs. Keene testified as to her recollection of the events surrounding the MCFD investigation of her use of the harness in August 2000, and the approval for its continued use which she received from Ms. Goddard. She denied all allegations of inappropriate discipline being used against the children who had reported these instances to the MCFD. Mrs. Keene described the events of the evening of January 24, 2001 which led up to Savannah's admission to PGRH, and her subsequent death.

Dr. Simon Earl was the Prince George pediatrician who saw Savannah on April 20, 1999 and October 11, 2000. It was during the second visit that Dr. Earl became concerned about Savannah's failure to thrive, and as a result, ordered further medical testing to investigate a worrying drop in her growth parameters. Dr. Earl testified that he had no contact with Savannah's social worker during the Fall of 2000 and early 2001. He was unaware that a restraint harness was being used on Savannah in order to deal with her night terrors, and was never approached by Mrs. Keene or any MCFD social worker to approve its use. Had he been asked, Dr. Earl testified that he never would have approved the use of such a restraint harness. In his view, this was the wrong way to treat a child who was suffering from a sleep disturbance, as the use of the restraint harness would most likely make the problem worse. Dr. Earl testified as to the limitations which he faced in his ability to collect all relevant medical history for Savannah, with the result that he was not getting her complete history, but simply "snapshots in time". He testified that in his experience, the flow of information between himself and members of the team who provided care to Savannah was inadequate. As an example, Dr. Earl testified that an important email message from Savannah's IDP worker to Savannah's social worker dated December 10, 1998 was not copied to his attention. Similarly, Dr. Earl's reports were not routinely sent to any social worker at MCFD, but only to the CDC and Savannah's family physician.

Dr. Earl testified that obtaining a complete and accurate patient history is critical to the assessment and treatment of children, particularly those who are non-verbal. The importance of obtaining a complete history was similarly agreed by all other pediatricians who testified at the Inquest. Dr. Earl testified that children with needs similar to those of Savannah need a high degree of consistency in their life, and do better in foster homes in which they are the only child. Dr. Earl also testified that he was surprised to learn that Savannah had only been seen by a pediatrician on two occasions during her life.

Mr. Blake King is a firefighter for the City of Prince George. He was on duty during the evening of January 24, 2001 with Mr. Paul Peterson and responded to a call for assistance at the Keene home which was made at approximately 1952 hours. He testified as to his very limited independent recollection of the events of that evening, and relied largely on the limited notes of his attendance that were contained in the Fire Rescue & Safety Report which was completed after the call. Mr. King testified that he recalled seeing no unusual bruising on the body of Savannah. He recalled that the child had difficulty breathing, and appeared to be in respiratory arrest. He recalled a suctioning device being used in an attempt to clear the child's airway. Mr. King did not physically handle Savannah, but was acting in support of the care which was being provided by his crew partner Mr. Paul Peterson. He recalled receiving a very brief history about Savannah having been laid down with a bottle, and then found in distress some time later. He had no recollection of seeing vomit in the bathroom where they were attempting the resuscitation, nor does he recall being shown the area where she was laid down with the bottle. He did not recall if there were other family members present, nor many other details as to the scene conditions. He agreed that firefighters typically make very few notes, but are instead devoting their entire attention to the care of the person in distress. He testified that there was nothing which they did to the child during the course of the resuscitation that might explain the bruising which was later observed on her body. He testified that it was a cold evening in Prince George, but that typically the last member of the fire crew would shut the front door of the house after they had entered.

Mr. Paul Peterson was the second member of the Prince George Fire Department that responded to the call to the Keene home during the evening of January 24, 2001. He similarly found it necessary to rely on the limited information contained in the Fire Rescue & Safety Report, as he had only a limited independent recollection of the observations which he made that evening at the Keene home. Mr. Peterson acted as the primary "attender" during the call to the Keene home, and relied on Mr. King to support him. He recalls that there were "gurgling sounds" coming from Savannah's mouth when he first assessed her. He described her as being dry and unconscious. He recognized that her condition was due to a blockage of the airway, and began to treat Savannah's respiratory distress in the bathroom of the Keene home. He had no recollection of where Savannah was when he first got there. He recalled that the child was clothed in a diaper. He had no recollection of any vomit being found on the child or in the bathroom where she was treated. He had not recollection of speaking to anyone from the family at the scene, but testified that the Fire Captain was present and filled out the Fire Rescue & Safety Report.

Mr. Tim Archer was one of the two ambulance paramedics that responded to the call from the Keene home during the evening of January 24, 2001. Mr. Archer was at that date qualified to the Advanced Life Support level, but was in the process of training to the more advanced Critical Care Transport level for which he is now qualified. Mr. Archer testified that he had no independent recollection of the events relating to Savannah's care, other than what was recorded in the Emergency Health Services Crew Report ("Crew Report"). Mr. Archer reviewed the Crew Report in detail, describing the information which is to be routinely entered, and the particular information that was contained on the Crew Report that was prepared for the Savannah Hall response. He described his recorded findings and treatment provided as described in the Crew Report. Mr. Archer frankly acknowledged that despite his best efforts, he did not always provide all of the required information on the Crew Report. Mr. Archer reviewed and adopted the statement which he provided to the RCMP on January 29, 2001.

Sgt. Heidi Wild of the Prince George Detachment of the RCMP described her role in conducting a review of the RCMP investigation into Savannah's death after additional information was brought to the attention of the RCMP by the B.C. Coroners Service. She and two other RCMP members reviewed the entire investigation file, and conducted additional follow-up interviews with a number of medical professionals who had been involved in Savannah's care. She testified that both the initial criminal investigation and the review investigation failed to provide sufficient evidence to support the laying of criminal charges as a result of Savannah's death. Sgt. Wild testified that in the absence of a definitive medical cause of death, there was no recommendation which could be made to Crown Counsel for the purpose of seeking a charge approval. The tape recorded 911 call made on the evening of January 24, 2001 from the Keene home was played to the jury. Sgt. Wild testified that the RCMP first became aware of Savannah's injury the day following her admission to PGRH as a result of a call from the MCFD. There had been no earlier notification to the RCMP of the events which took place at the Keene home the previous day resulting in Savannah's admission to PGRH.

Dr. Ken Poskitt testified by video conference from B.C. Children's Hospital in Vancouver. Dr. Poskitt is a pediatric neuro-radiologist, with specific expertise in the imaging of the brain and spinal cord of children. He has conducted approximately 3,500 to 4,000 studies per year during the last 21 years of his career. Dr. Poskitt provided the jury with an explanation of the primary imaging modalities upon which he relies: CT and MRI. Dr. Poskitt testified that his case review of Savannah's death was primarily based upon the findings of the PGRH admission CT performed at 2200 hours January 24, 2001, and the follow-up CT performed at B.C. Children's Hospital on January 25, 2001 at approximately 1630 hours. Dr. Poskitt prepared a report of his findings dated July 27, 2007. Dr. Poskitt's opinion was directed at answering two questions: What happened to cause the hypoxic ischemic brain injury, and when did this event happen? Dr. Poskitt testified that Savannah's cerebral edema was diffuse, bilateral and symmetric. This pattern of edema was not as a result of a focal injury, but resulted from some type of injury which involved the entire brain.

Based upon his review of the two CT studies, Dr. Poskitt testified that he was able to state with 99.9% certainty that the anoxic event which caused the injury to Savannah's brain must have occurred anywhere between 24-48 hours before the time of the first CT at 2200 hours on January 24, 2001. In considering the cause of this anoxic injury, Dr. Poskitt testified that the most common type of injury which results in the observed pattern of cerebral edema is a systemic insult such as asphyxia. Although this type of diffuse cerebral edema is most commonly seen in abuse cases, the absence of other typical accompanying findings left Dr. Poskitt unable to definitively conclude that abuse was the cause of the anoxic injury. He stated that he was not saying that a finding of abuse was impossible or unlikely, but simply that he was not able to prove it on the available medical evidence to the degree of scientific proof that he considered appropriate. In his opinion the asphyxial event which resulted in the anoxic injury to the brain preceded the formation of the cerebral edema. The anoxic injury resulted from a decreased delivery of oxygen and glucose to the brain. The cause of this decreased delivery of oxygen and glucose was either as the result of a natural event, or an accidental cause.

Based on the clinical evidence, Dr. Poskitt was able to rule out a natural event as having caused the decreased delivery of oxygen and glucose to the brain, leaving him to consider which accidental event might have caused this anoxic injury. Dr. Poskitt testified that "someone or something" asphyxiated Savannah.
In describing what he meant when he stated that "something" could have asphyxiated Savannah, Dr. Poskitt said that in his experience the "something" would have had to have been either a fall into water, or the child smothering to death in a plastic bag. He did not think it possible that Savannah could have asphyxiated herself by lying face down in bed. Dr. Poskitt ruled out the possibility that Savannah asphyxiated on the contents of her bottle because the findings on the first CT scan taken at PGRH told him that the injuries were considerably older than the few hours which had elapsed since Savannah had been given the bottle.

Jennifer Heppner, a relative of Corinna Hall, testified as to her recollection of Ms. Hall's pregnancy, and an event which occurred during a supervised visit between Ms. Hall and Savannah in approximately mid June, 2000. Ms. Heppner testified that to her knowledge, Ms. Hall did not drink or use drugs during her pregnancy with Savannah. After Savannah was born, she would often visit with the Corinna and Savannah. She testified that on June 10, 2000 she went with Corinna to a supervised visit with Savannah at the MCFD offices. During that visit, both she and Corinna observed bruising to both of Savannah's legs below the knees, and on the side of one knee. When this was brought to the attention of the social worker they were told that they could ask Mrs. Keene about the bruising. Ms. Heppner testified that when asked about the bruises, Ms. Keene said that Savannah was "clumsy" and that is why there were bruises. Ms. Heppner also testified that Savannah appeared unhappy to see Ms. Keene when she arrived to pick her up from the visit. The MCFD document "Supervised Visit and Transportation Record" documents the visit, records information regarding those in attendance, and makes note of any significant events which occurred during the visit.

CORONER'S COURT OF BRITISH COLUMBIA

held at Prince George, British Columbia

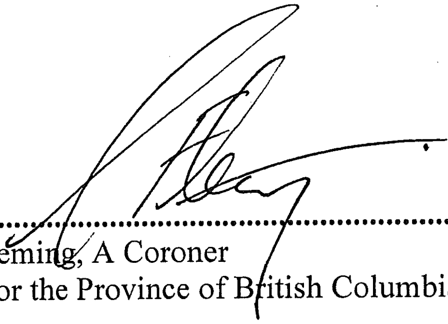
VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

HALL	Savannah Brianna Marie
SURNAME	GIVEN NAMES

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:



Scott Fleming, A Coroner
In and for the Province of British Columbia

BRITISH COLUMBIA

CORONER'S COURT OF BRITISH COLUMBIA

held at **Prince George** , British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

HALL	Savannah Brianna Marie
SURNAME	GIVEN NAMES

RECOMMENDATIONS OF THE JURY

To: The Honourable Tom Christensen
Ministry of Children and Family Development (MCFD)
PO Box 9057, Stn Prov Govt
Victoria, BC V8W 9E2

1. MCFD should improve their procedures relating to the recording and sharing of all information, relating to both substantiated and unsubstantiated allegations, which may relate to the safety and welfare of children in care.

2. MCFD should develop and implement a single document, equivalent to the "Child Services Case Snapshot", which records all allegations against a foster home.

3. MCFD should require that foster parents be trained in First Aid and CPR.

4. MCFD should revise and clarify the Standards for Foster Homes as it relates to the use of both mechanical and physical restraints. These Standards should specifically require the approval of a physician prior to their non-emergent use.

5. MCFD should revise the Supervised Visit and Transportation Record so as to require the signature of the visiting natural parent, and that a copy of the record is provided to the natural parent.

6. MCFD should require immediate notification to the applicable police agency of all serious incidents involving physical injury to children in care.

7. MCFD should require that it be notified of all physician visits made by children in care.

8. MCFD should ensure the availability of social workers to promptly respond to and investigate allegations involving potential harm to a child in care in those situations in which the child's assigned social worker is unavailable.

9. MCFD should ensure that foster parents are provided with all available information regarding a child's history within 72 hours of placement.

10. MCFD policies should require that all resources providing service to children in care immediately report to the MCFD, and the MCFD investigate, unusual periods of absence from the resource.

11. MCFD policies should require that after hours social workers have access to information relating to the proposed foster home. Such information to include: number of children presently in care, the level of care provided by the foster home, and the history of allegations made against that foster home.

12. MCFD information management systems should track all allegations made against a foster home, including those relating to both Quality of Care and Abuse or Neglect.

13. MCFD policies should require a medical assessment before placing a special needs child in care.

14. MCFD policies should require that all social workers involved in the care of children in a foster home be provided with a copy of the Annual Review of that foster home.

15. MCFD policies should require that all allegations of Quality of Care and Abuse or Neglect be independently reviewed by workers that are not involved in the management of the foster home, or the care of children placed within that home.

16. MCFD policies should require that Guardianship workers visit each child in care on their caseload not less than twice yearly.

17. MCFD policies should require that the resource social worker review with each foster parent, at least once every five years, the then applicable Standards for Foster Homes.

To: Mr. Lee Doney
A/Executive Director
British Columbia Ambulance Service (BCAS)
PO Box 9600 Stn Prov Govt
Victoria, BC V8W 9P1

18. BCAS should modify the form of its Crew Report to allow for extra room for the recording narrative.

19. BCAS should emphasize the requirement and importance of full charting of the Crew Report by all attendants.

To: Mr. Jeff Rowland
Chief, City of Prince George Fire Department
1111 7th Avenue
Prince George, BC V2L 3N8

20. The City of Prince George Fire Department should require a full recording on its Fire Rescue and Safety Report of all significant scene circumstances when responding to calls involving personal injury.

To: Mr.Darrell Roze
Executive Director
Child Development Centre of Prince George & District ("CDC")
1687 Strathcona Avenue
Prince George, BC V2L 4E7

21. CDC should revise its procedures to improve reporting and communication with the MCFD regarding children in care.

22. CDC should require notification to the MCFD of any unexplained absence of longer than two days of any child in care.

23. CDC should require the reporting to the MCFD of any observations of suspicious bruises on children in care.

To: Dr. M. VanAndel
Registrar
College of Physician & Surgeons of British Columbia ("The College")
400 – 858 Beatty Street
Vancouver, BC V6B 1C1

24. The College should recommend to its members that they deliver to the MCFD copies of Consultation Reports relating to patients who are children in care.

25. The College should recommend to its members that the patient history regarding children in care be taken from other health professionals and MCFD workers, in addition to the history obtained from foster parents.

CORONER'S COURT OF BRITISH COLUMBIA

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VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

HALL	Savannah Brianna Marie
SURNAME	GIVEN NAMES

To: **The Honourable George Abbott**
Ministry of Health (MOH)
PO Box 9050, Stn Prov Govt
Victoria, BC V8W 9E2

26. The MOH should investigate the development of a website which provides a central repository for medical information regarding children in care.