CORONER'S COURT OF BRITISH COLUMBIA

held at **PRINCE GEORGE**, British Columbia

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 11 June, 2007 at PRINCE GEORGE Court House, British Columbia, and continued on the following dates June 11 - 14 2007 into the death of SIMPSON, AMANDA JEAN find she came to her death at approximately 1430 hours on the 2nd day of NOVEMBER AD, 1999 at or near VANCOUVER, British Columbia

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) craniocerebral trauma as a result of non-accidental injury

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

DUE TO OR AS A CONSEQUENCE OF

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

(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 14th day of June AD, 2007.

BETH LARCOMBE
Presiding Coroner's Printed Name

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age:	4 years	Gender:	☐ Male	☒ Female	
Date of Birth:	16 December 1994	Native:	☐ Yes	☒ No	
Coroner's Case No.:	1999:659:0033	Post Mortem:	☒ Full	☐ External	☐ None
Police File No.:	99-32296	Toxicology:	☒ Yes	☐ No	
Police Department:	RCMP/Major Crime/Pr George	Identification Method:	☒ Visual	☐ Other	(specify below)
Court Reporter:	Alana Siemens	Identified by:	Mother		
Phone:	250-561-0048	Premise of Injury:	Private Residence		
		Premise of Death:	Hospital		

INTRODUCTION

This inquest into the death of Amanda Jean Simpson commenced at 0930 hours on June 11, 2007, at the Courthouse, Prince George, BC, and continued on June 12 - 14, 2007. Ms. Mailyne Ouelette and Mr. Richard Meyer appeared on behalf of the Ministry of Children and Family Development (MCFD) and staff. Mr. Richard K. Gabruch appeared on behalf of Mr. Rory Polson and Ms Jerry Walton, and Mr. David Pilley appeared on behalf of Dr. Marie Hay. Coroners counsel was Dr. Syd Pilley. Sheriff Eric Lablond took charge of the jury and recorded the following exhibits:

1. Group of 12 residential photographs on Oak Street, Prince George
2. Floor plan diagrams of the residence on Oak Street, Prince George
3. Police continuation record of conversations with Mr. Polson
4. Police statement of Ashley Simpson (sibling, then 8 years old) taken November 1999
5. Consultation report of Dr. Marie Hay, Paediatrician
6. Consultation report of Dr. Margaret Colbourne, Paediatrician
7. Final Autopsy report of Dr. Glen Taylor,*[1] Forensic Paediatric Pathologist
8. Letter report from Dr. Laurie McKinnon, R.Psych. counselor of 3 siblings
9. Group of 23 photographs of Amanda Jean Simpson*
10. MCFD Intake Reports
11. MCFD Director's Case Review recommendations (13)
12. MCFD Intake summary and disclosures*
13. Registration of Death

The following witnesses testified:

1. Jerry Walton (mother)
2. (Ronald) Rory Polson (mother's boyfriend at the time)
3. Rick Gremm, hospital social worker
4. Val Huber, RN. nurse Prince George Regional Hospital
5. Dr. Marie Hay, (paediatrician on call Oct 30, 1999 at Prince George Regional Hospital)
6. Julia Lamming, Child Development Centre Supervisor
7. Dr. Margaret Colbourne, Paediatrician, BC Children's Hospital
8. Dr. Glen Taylor, Forensic Pathologist
9. Cpl. Mike Stevenson, RCMP case file coordinator

*[1] Disposition order made by presiding Coroner: For disclosure only with approval from Coroner Larcombe or Chief Coroner

10. Gail Morrison, MCFD Social Worker
11. Michelle Olexyn, Youth Care Worker Ron Brendt Elementary School, Prince George
12. John Bird, former MCFD Social Worker
13. Beth (Chamberlain) Quesnel, former MCFD Social Worker
14. Robert Watts, Director of Child Welfare, MCFD Northern Region

PRESIDING CORONER'S COMMENTS

The following is a synopsis of the 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.

Amanda Jean Simpson was four years old when she died on November 2, 1999 at BC Children's Hospital (BCCH) in Vancouver. She was taken from her home to the Prince George Regional Hospital (PGRH) at 2315 hours on the night of October 30, 1999, by her mother, Jerry Walton, and her mother's boyfriend, Rory Polson. Amanda arrived at PGRH emergency department unresponsive, hypothermic (core temperature of 32.5C) and suffering from a significant and obvious head injury. Later examinations revealed she had also suffered significant internal abdominal injuries and a broken collar bone along with what was found to be a lethal fractured skull and traumatic brain injury.

History provided at the inquest from the mother indicated Amanda was well, with no sign of injury at 2000 hours October 30, 1999, when the mother left the residence to go to work. Amanda and her three sisters aged eight, six and two, were left in the residence with Mr. Polson.

At approximately 2300 hours, the mother received a call at her place of work from Mr. Polson and immediately left for home. She had been advised that Amanda was hurt. She stated she arrived home and found Amanda lying on the bathroom floor. She did not remember where Mr. Polson was at that time. Amanda was not breathing; she was not bleeding. She did not remember what Amanda was wearing, and testified she did not bathe or shower her. The mother remembered Mr. Polson picking up and carrying Amanda while they drove to the hospital. She had no idea of the time. She called a babysitter from the hospital to watch the three remaining children. When asked by counsel how Amanda came to be injured, Ms. Walton testified that she was told Amanda may have fallen off her bunk bed. Ms. Walton could not explain the injuries Amanda received and confirmed there was no bleeding, no bruising, 'just a bump on her head'.

Under cross examination, Ms. Walton stated that Mr. Polson had told her Amanda might have fallen from the bunk bed. He did not mention that Amanda might have fallen down the stairs or against the bathtub. Ms. Walton denied that she and Mr. Polson left the hospital while the medical team was attending to Amanda. She

confirmed that she was told at the hospital that Amanda's injuries were not consistent with the history presented.

Ms. Walton's counsel asked about the family dynamics. Ms. Walton stated they were 'normal'. The girls did run and play on the stairs. When asked about the bunk bed, Ms. Walton testified that Amanda slept on the top bunk and her little sister slept on the bottom bunk. Ms. Walton confirmed she was the disciplinarian in her home rather than Mr. Polson as the girls were her children. She stated the girls did not need a lot of discipline. She confirmed there was no domestic violence between herself and Mr. Polson, and no violence directed at the children.

Mr. Polson was next to testify. He stated that he had no favourite of the four sisters. He was with Amanda mostly because she was home the most. When it came to discipline, he stated that the mother spanked the girls, and he yelled at and spanked them. When questioned about the events of October 30, 1999, Mr. Polson remembered that he worked that day and stayed after work with colleagues. He had five or six beer and a shot of rum before going home at approximately 1915 hours. He did not think he was impaired because, he said, h drove home. He testified that Ms. Walton was rushing to work for 2030 hours. He left the house to get "McDonalds" for supper, but couldn't remember if Ms. Walton ate. He testified that the girls went downstairs into the basement after eating, probably to watch a movie, but he was not sure. He stated he called to them at 2230 hours to get ready for bed. He was upstairs trying to start a fire in the living room when he heard Amanda come up first. He testified he then heard a commotion on the stairs. Soon afterward the eight year old sister had come up to him carrying Amanda; she said she had found Amanda at the bottom of the stairs.

His recollection of Amanda's condition when he first saw her was that she was not responding; she had a lump on the right side of her head. He went to get a bag of frozen vegetables to put on the lump. Amanda threw up so he took her to the bathroom. She was unconscious and moaning; there was no bleeding. He put her in the tub and turned on the cold shower to revive her, he estimated for two or three minutes. He testified he was holding her across the front of his body when he entered the bathroom and tripped on the carpet. He fell forward and his body and Amanda hit the tub.

He testified Amanda moaned when he called her name and that she seemed to rouse. He remembered Ms. Walton getting home quickly after he called. When asked where the other children were, he thought they were all downstairs. When asked why he did not call 911 and get an ambulance, he testified that he did not think to do that. He did not remember if he changed Amanda's clothes. He remembered carrying her into the emergency department, and the nursing staff taking her.

He was questioned as to what he said to hospital staff when asked what happened to Amanda. He did not remember telling the medical team or Ms. Walton that he found Amanda on the floor of the girls' bedroom or that she had fallen from the top bunk.

Mr. Polson confirmed that he was arrested on October 31, 1999, and was kept in Prince George RCMP detachment cells for three days. He did not have an opportunity to speak to Ms. Walton until November 1, 1999.

Coroner's Counsel questioned Mr. Polson about his understanding of Amanda's condition. He stated that at PGRH he was told that she was probably not going to make it. He remembered crying and having a nose bleed. He remembered there were two doctors, two nurses, and a social worker with them when they were told.

When presented with the time line being problematic based on Amanda's condition and the report he made to the medical team at PGRH, Mr. Polson maintained that he heard a commotion just before seeing Amanda, and that the time was ± 2230 hours. Coroner's Counsel referred to a statement in evidence taken from Amanda's sister, where she said it was 2100 hours and knew that because of a TV program. Mr. Polson stated she was mistaken. When asked if he could explain Amanda's extremely cold body temperature, his response was he thought it would have been from the cold shower.

Coroner's Counsel reviewed each of Amanda's injuries with Mr. Polson. In response, he stated that the collar bone fracture could have occurred when he fell against the bathtub with her in his arms, and the bruising to her left side could have occurred then also. He stated the severe abdominal injuries could also have occurred then; he denied shaking her violently. He agreed the lump on her head was there when she was brought upstairs.

In the statement made by Amanda's sister, she recollected that Mr. Polson called Amanda and her three year old sister upstairs after supper because they had been too noisy. Mr. Polson denied this. He was asked if he ever pushed the children down and stomped on their tummies as the girls had stated. He denied this. He was asked if he ever held them high around the throat and then dropped them. He denied this. When asked if he ever threw them around, he denied this. Coroner's Counsel asked if he accepted that his account of falling in the bathroom may have caused Amanda's serious injuries; Mr. Polson said yes. He stated it was an accident and that he did not intend to hurt Amanda.

Under cross examination Mr. Polson agreed that the stairs were often cluttered with shoes on the sides, but no large heavy objects. He testified he felt the lump on Amanda's head, but could not see it. He was asked if it was 'mushy' or 'boggy' as had been stated by Amanda's sister and nursing staff. Mr. Polson could not remember. Other Counsel asked if the older sister had called to him as she brought Amanda up the stairs. He replied no. When counsel questioned whether he thought this was odd, Mr. Polson replied he did not know. Mr. Polson

again stated the time this occurred was 2230 hours or sometime after. He put Amanda in the bathtub and ran cold water on her for two or three minutes; he did not remember if the bath plug was in or out. He was asked if he deliberately misled the doctor and police. He denied this and added that he did not provide a statement to the police, nor did he recollect talking to the police.

Mr. Polson's counsel wanted to know what the older sister said when she brought Amanda upstairs. Mr. Polson testified he was told Amanda was hurt and that she fell down the stairs and was hurt. He was asked if he threw the girls down the stairs and he denied this. He was asked if he heard anything before seeing Amanda. He said no. He was asked if he ever made them cry to which he replied no. His counsel asked if he had heard crying to which he replied he had heard nothing. He confirmed the amount he drank after work and stated that he didn't think he was drunk; he drove home. When asked to state again how he was holding Amanda when he fell, he testified he was holding her with her facing toward him and her head to his right side. Mr. Polson's counsel asked about his relationship with the four girls. He testified that he played with the girls. They would get on his back. He would spin them around in a game of 'airplane' that he would 'fake step' on them, and he never scared them.

Mr. Polson repeated that his form of discipline was spanking and yelling. His counsel asked about the MCFD involvement. Mr. Polson testified he didn't remember much. No one from MCFD ever talked to him. He was reminded about a charge of sexual assault reported to MCFD. He testified that he 'checked up' on that and the findings were negative. He knew there were other reports but not what they were.

He testified that he had no recollection of what he had said to the police. He did not recall making a statement – 'just talk'; he did recall being at the police detachment for quite a while. He testified that he had used cold water on Amanda because he remembered learning somewhere that would revive someone. He confirmed that he and Ms. Walton now have two children of their own aged four and six. He confirmed that MCFD were involved initially under a court order, and that he and Ms. Walton had been supervised, but not any more. He denied ever intentionally hurting Ms. Walton's four girls or his own two children.

Jurors asked Mr. Polson if the bump on Amanda's head was visible. He testified he didn't remember seeing it. He was asked if she was breathing. He testified she was before he fell on her. Mr. Polson testified that he had the five beer and shot of rum over a period from 1730-1915 hours. Jurors also asked Mr. Polson about getting a breathalyzer test at the police detachment. He confirmed that had happened. They asked whether the doctors at PGRH asked him what happened. He replied he couldn't remember. He was asked what he said to the RCMP about the bunk bed. He replied that he could not remember.

The social worker (SW) at PGRH on duty the night Amanda was brought in spent time with Ms. Walton and Mr. Polson in an emotional support role. Medical staff reported to him that Mr. Polson was inebriated, but th

SW testified he did not see that himself. He was advised by hospital staff the child had fallen from a bunk bed at approximately 2000 hours.

Hospital staff testified they were told by Mr. Polson that Amanda had fallen from the top bunk in the girls' basement bedroom and that he had found her unresponsive on the floor of the bedroom. Initial examination of Amanda's injuries caused the hospital staff to question the history presented. A CT scan of Amanda's head revealed a massive skull fracture and brain swelling.

Nursing staff testified that there was a large bump on Amanda's head and it was very apparent the child had suffered a critical injury. She had a weak pulse and no effective spontaneous breathing. The emergency room physician attempted to intubate Amanda to assist her breathing. A large amount of blood at the back of her throat was suctioned away. At some point during the resuscitation attempt the 'parents' (assumed by hospital staff and so referred in the charting) advised a nurse that they were leaving the hospital.

Amanda was dressed in underwear and little black socks. She was very cold and mottled around the mouth. A nurse testified that she had never felt a child this cold.

Dr. Marie Hay, Paediatrician, qualified as an expert witness, testified that in her opinion the history given to her was not at all consistent with the physical and clinical condition of Amanda when she examined her at 2330 hours on October 30, 1999.

Dr. Hay referenced her notes and summary in her testimony. She presented evidence of a child who arrived shocked, pale, pulseless, decorticate (body posture indicative of a significant brain injury) with a massive soft swelling of her head, and the child was ice cold.

Emergency resuscitative measures were initiated and when the medical team stabilized Amanda enough she was taken for a CT scan of her brain. This revealed massive bilateral comminuted (broken into pieces) skull fractures that showed elevation, an indication of massive brain swelling. Once Dr. Hay managed to stabilize Amanda enough, she attempted to speak to the family; neither she nor her staff could locate them. Staff testified the 'parents' had left the hospital.

Dr. Hay testified the history she received from Mr. Polson was as follows: the four children were downstairs, he was unaware of the time, he had been drinking and that sometime after 2000 hours, the children had eaten and gone downstairs. Mr. Polson informed Dr. Hay that he heard Amanda cry a couple of times and he went downstairs. He told Dr. Hay that Amanda had a blank stare and that he carried her upstairs. He said he found her at the bottom of the ladder of the bunk bed, and the three year old was sitting up on the top bunk. He reported Amanda's nose was bleeding, her head was boggy and puffy, and that she vomited. He reported getting

frozen vegetables to put on her head, but that the swelling got bigger and bigger. She was not conscious. Dr. Hay got a later report from Amanda's mother who informed her that she had returned home from work, called a babysitter, put some clothes on Amanda and drove to the hospital. She told Dr. Hay they were delayed getting to the hospital while they waited for the babysitter. She told Dr. Hay that the three year old child slept on the top bunk as Amanda tended to fall off.

Dr. Hay testified that she had previously examined Amanda and her sisters at the Northern Child and Family Clinic which examines children suspected of being abused or neglected. MCFD had referred this family to Dr. Hay in June 1999, due to concerns of physical abuse and neglect that had been reported by school staff. Dr. Hay's report at the time noted inflicted injuries on Amanda's back but that the history presented to her by Amanda fit the pattern of bruising that she observed. Therefore, she could not find evidence of abuse at that time. Dr. Hay did diagnose a genetic anomaly for a protein deficiency, and recommended follow up care in her clinic.

In summary, Dr. Hay found a four year old girl with massive and severe head injuries with retinal hemorrhages severe bilateral comminuted skull fractures, severe cerebral edema (brain swelling), in a coma, severely hypothermic, multiple bruises on lower limbs and left hip, well established coagulopathy, and biochemical abnormalities. The injuries could not have occurred from a fall as described by Mr. Polson. Dr. Hay testified that in her opinion the massive head trauma occurred before the alleged bathroom injury.

Returning to when Amanda was admitted to PGRH, Dr. Hay testified that an immediate transfer to BC Children's Hospital (BCCH) was arranged. Due to the extent of the injuries and Amanda's unstable condition a BCCH Paediatric Itensivist flew up in the plane to accompany Amanda and her mother to BCCH. The request for transport was made at 0235 hours October 31, 1999; the Infant Transport Team from BCCH left Prince George at 0400 hours.

Dr. Margaret Colbourne was the Paediatrician attending when Amanda arrived in Vancouver at B C Children's Hospital. She was testifying as an expert witness in the specialty of child abuse and neglect. Her initial examination confirmed the PGRH findings.

Dr. Colbourne testified that she was struck by three things on examining Amanda. First, the very severe head injury which was not consistent with a fall from a bunk bed; second, the extensive bruising and trauma not often seen in concert; and thirdly the low core temperature on arrival at PGRH. Dr. Colbourne testified that children do not cool off that fast.

She testified that the abnormal vital signs Amanda presented with are not often seen in children. In her opinion Amanda was in shock due to blood loss and neurogenic shock. On examination she found extensive bruising o:

the right side of Amanda's head. The right eye was swollen shut and could not be examined; the left eye pupil was fixed and dilated with retinal hemorrhages visible. She testified that there was a number of bruises to the lower legs that are usually seen in children and of no concern, but there was also bruising over the anterior chest wall clustered in a linear fashion consistent with finger marks and seen in cases of violent shaking. She observed extensive bruising to the right elbow and the left hip.

Dr. Colbourne described the very severe swelling in Amanda's brain that covered two layers and noted that there did not appear to be a large amount of blood, however, the degree of brain swelling was extraordinary. A CT scan of the abdomen indicated a severe bowel injury as free air and solid material had accumulated in the abdominal cavity. In addition Amanda had suffered a fractured right clavicle. Her haemoglobin had dropped from 105 in PGRH to 62 at BCCH (normal range for a child 1-6 years would be 90.5 to 140). Dr. Colbourne explained the effects on the body when metabolic imbalance occurs from severe injury and blood loss and how the different systems cannot maintain the necessary balance and stability to sustain life. Dr. Colbourne testified that the one treatment that Amanda required for the internal injuries was contraindicated to the brain injury. The abdominal injury by itself would have required immediate surgery, but in Amanda's case this could not happen due to her severe brain injury and unstable condition.

Dr. Colbourne testified that Amanda would have had immediate symptoms from an abdominal injury of this kind which could be viewed as similar to a seatbelt injury across the lower abdomen. She testified that a fall down stairs could not result in a constellation of injuries as presented on Amanda's body. When asked her opinion of what would cause such injuries like Amanda's, Dr. Colbourne testified they would be consistent with a fall from a significant height, such as a second story building, and not from a fall off a bunk bed or a fall down stairs. She testified only 1% of children suffer a fractured skull from falls under eight feet.

Dr. Colbourne went on to testify that she did not believe either of the two versions of events presented by Mr. Polson, as they did not explain the injuries Amanda suffered. She stated how unusual it was to have core body temperatures below 34 or 35 Celsius, and that a drop to 31 Celsius, as in Amanda's case, could not have occurred in such a short time line.

On questions from the jury, Dr. Colbourne stated it would take several hours for the full extent of the injuries to be visible on the surface of the body. In her opinion, the bruise pattern on the left and right side of Amanda's flank was caused by finger marks. She testified that Amanda suffered multiple blows to the head, the trunk and the hip areas, and that they could not be explained by the history presented. In her opinion, the injuries were consistent with Battered Child Syndrome. She testified that in her opinion Amanda was "beaten to death".

On November 1, 1999, a BCCH Paediatric Intensivist informed the family that Amanda could not survive the injury to her brain. They were informed of the requirement to determine brain death and if that was the case the

child should be removed from life support. The neurological testing confirmed brain death and on November 2, 1999, at 1405 hours, Amanda was removed from life support. She died at 1430 hours.

Dr. Glen Taylor, Forensic Paediatric Pathologist was next to testify and be qualified as an expert witness. Dr. Taylor testified that he conducted an autopsy on Amanda Jean Simpson on November 5, 1999, at the BC Children's Hospital. The autopsy report was entered as an exhibit; Dr. Taylor provided testimony and opinion.

Dr. Taylor found that Amanda died from craniocerebral trauma as a result of non-accidental injury.

He testified that he did not see injuries like this very often, i.e. multiple injuries to multiple areas on a child's body. In his opinion, the injuries he examined on Amanda's body came as the result of high energy impact. In Dr. Taylor's opinion a short fall would be anything less than ten feet, and the pattern of injuries found on Amanda's body suggested they were not accidental nor as the result of a short fall. Dr. Taylor testified to all the injuries he examined.

The presence of retinal hemorrhages in both eyes indicates a suspicion of shaking, Dr. Taylor said, but research over the past several years has found they are not necessarily specific to shaking and can be caused by significant head trauma such as Amanda had suffered. He testified that in the four or so years he worked at the BC Children's Hospital he had only seen three or four cases of children who had suffered such extreme injuries.

Coroner's counsel asked Dr. Taylor which of the injuries in and of themselves could cause death. Dr. Taylor testified that massive blood loss in and around the skull of young children can cause fatal hypovolemia (blood loss); the abdominal injury suffered could have caused death. In his opinion, however, the head injury was the primary injury that caused Amanda's death.

Dr. Taylor was asked if the second scenario presented by Mr. Polson (of Amanda falling down the stairs) would be consistent with the injuries he examined. He testified that potentially it could be consistent, but that you would usually expect only one injury in such a fall. He felt some of the bruising injuries could be consistent with a fall downstairs except for the series of four linear bruises to Amanda's side and back which indicated a finger pattern. The retinal hemorrhages could possibly be consistent, as could the fractured clavicle. Dr. Taylor testified that it was unusual for a child to suffer a significant head injury with a loss of consciousness or a fractured skull from a fall down the stairs.

Coroner's Counsel asked Dr. Taylor if the abdominal injuries could have been caused by a fall down stairs. He testified that he could not imagine they could be. He responded "basically no", as the force of the injury Amanda suffered to her abdomen was from front to back. A juror asked Dr. Taylor if a foot on the stomach could have caused the abdominal injury. Again Dr. Taylor testified it could be possible, but that in hi

experience it was not like a stomp injury as that force tends to leave a pattern injury on the surface of the skin. Amanda had no pattern bruising to the skin surface; she had severe internal injury indicating a forward to backward punching or kicking force.

The juror wanted to know what kind of force would cause the kind of skull fracture that Amanda suffered. Dr. Taylor testified he had seen such injuries in cases where a child's head had been run over by a car.

Coroner's counsel asked Dr. Taylor if the fall against the bath could have caused the skull fracture. He testified it would be a guess on his part as he had no prior knowledge of this scenario nor how it was alleged to have occurred. He did agree that he had not seen such severity of injuries in a fall down stairs.

Dr. Taylor was asked by Mr. D. Pilley if a motor vehicle accident could account for the injuries and he responded that only if the child had been ejected and a wheel had run over her head. Mr. D. Pilley asked Dr. Taylor if he had any recommendation that could be considered. Dr. Taylor felt that support for a body of research to support the biomechanics of injury would be helpful for reconstructing and measuring forces needed to inflict certain injury patterns. He felt it would assist physicians, police and lawyers.

Mr. Gabruch asked the pathologist if an impact to the head like this would bleed. Dr. Taylor thought it unlikely it would bleed from the impact point, but severe skull fractures bleed from the ears, nose and mouth. When asked about the ages of the bruising and if it could have occurred over time, Dr. Taylor testified that the bruised tissue was examined microscopically and the bruising occurred at the same time. Counsel asked again if the fall against the bathtub could have caused the fracture. Dr. Taylor testified that he would expect to see a linear parietal fracture only, not the bilateral comminuted fracture he found. He added that in the case of a linear fracture, the children are awake and stay alive.

At the end of his testimony, Dr. Taylor was asked by a juror to give an opinion from one to ten of the scenarios presented and whether any could have caused the fracture to Amanda's skull with one being the lowest possibility. Dr. Taylor answered one out of ten.

Dr. Taylor's report comments:

"This child died from a severe head injury. She had a complex skull fracture that extended into the basal skull. The fracture radiated in several arms from a point above the right ear, which corresponded to a scalp abrasion. The abrasion showed no specific imprint patterning, possibly due to cushioning from the scalp hair. The right ear had several abrasions/bruises. The skull bones were normally thick and had normal resiliency. There was no laceration of the scalp. Contusions, brain laceration related to splitting of the left parietal bone, and brain swelling were present. Both eyes showed retinal and optic nerve sheath hemorrhages. There was fracture of the

right clavicle but no other acute or older fractures as determined by gross autopsy examination and skeletal X-ray survey. Fresh bruises were present over the arms around the elbow, left posterior upper chest, and over the pelvic ridges at the back. Some older bruises were present around the knees.

Internally there was marked distension of the stomach with necrosis of the stomach wall and localized peritonitis. Some bleeding into the wall of the stomach was associated with this but there was no other intra-abdominal hemorrhage. The pattern of the scalp injury, complex fracture and coup/contra coup contusions indicates a broad-surface high-energy impact against the right side of the head over the right ear and right temporoparietal region. The right clavicular fracture could result from the right shoulder taking some of the force. This child also had bilateral retinal and optic nerve sheath hemorrhages. These raise strong suspicion that an episode of acceleration/deceleration injury, such as with shaking, occurred. The abnormality in the stomach is consistent with a blunt impact inflicted on a stomach containing a full meal causing some stomach bleeding then necrosis and infection. The child's multiple bruises over both hips, left side of the back and inside of the right arm cannot be satisfactorily attributed to a simple fall from a few feet. The type of force required to cause this child's head injury is that seen with motor vehicle accidents, long-distance (more than a story) falls or wit blunt objects like a board being swung with force against the head. It could also result from the child being slammed against a wall or other flat surface".

In Dr. Taylor's opinion, the injuries were not consistent with an accidental fall of four or five feet onto a carpeted floor. The head injuries were also not in keeping with the head impacting onto a carpeted surface after a short-distance fall.

The nature of the head injury and other findings indicated the child suffered inflicted injuries, not accidental ones.

After her death, Amanda's three sisters received grief counseling from MCFD through Dr. Laura McKinnon, a licensed psychologist. Dr. McKinnon's summary was presented into evidence. The summary was from a January 7, 2000, visit where the girls acknowledged that Amanda was dead and with the angels. They gave great detail as to the events of the evening of October 30, 1999 in the home, and reported seeing Amanda assaulted by Mr. Polson. The jury had been cautioned by the presiding coroner to be mindful of the children's age when considering this evidence and the weight they applied to it.

Following Amanda's death, the Provincial Director of Child Welfare ordered a review of the Ministry of Children and Family's involvement with this family. An initial Deputy Director's Review (DDR), which is limited to a review of files and other documents, indicated a further review was necessary. The second level of review is the Director's Case Review (DCR); a comprehensive review process that includes the development of a chronology, the establishment of findings as defined in the terms of reference, analysis to support the findings

and recommendations. It has distinct stages that involve reviewing files, reviewing collateral documents, the completion of interviews and fact verification.

A request to enter the Director's Case Review into evidence received strong objection from the MCFD counsel Mr. Richard Meyer, citing it was a report based on a third party review of the facts; opinion evidence only. Mr. Meyer objected to the jury receiving opinion based evidence of the investigator mixed in with facts and argued that the report would be prejudicial. Other counsel had no objection to the admissibility of the document.

The decision rendered by the presiding coroner allowed for the inquest to continue such that the forthcoming witness testimony would address the intent and findings in the report with a reserved right for the coroner to raise the issue again if in fact the issues remained unaddressed in testimony. Counsel for the Ministry had no objection to the recommendations within the DCR being entered in their entirety.

Ms. Morrison, a social worker in the Prince George MCFD Regional Office, testified to MCFD process and policy in the child protection division. She testified, they first receive a report, ask probing questions and do an intake which is entered on an electronic system. The social worker will then do an assessment which will indicate whether they do an investigation or not or alternatively are they going to offer support services. The steps taken if an investigation is warranted continue with a prior intake check on the MCF system, review the history documented, do a collateral check by interviews and then proceed to a full investigation. They focus on a balance of maintaining the family integrity against the child's safety. All efforts are made to keep a family together. Ms. Morrison testified that a family service worker would review the history and current concerns. Follow up would measure whether the family is reaching the milestones expected. The intake worker becomes the case manager and that file remains with that worker if an investigation follows.

Ms. Morrison testified the cases are closed when the worker is satisfied and their supervisor has reviewed and signed off on the case.

Coroners Counsel asked Ms. Morrison to review the Simpson child welfare history for the jury. She testified that the family first became known to MCFD in 1991 and that there had been 14 calls of concern between 1991 and 1994, consisting of one report of physical abuse and spousal violence, and the family seeking services through anger management, 12 reports were for neglect, a report about marijuana use by the parent, alcohol abuse and no food in the home, also concerns raised about the caregiver that the parent(s) left with the children. She testified that services were offered to the family twice in this time, and twice refused.

Ms. Morrison testified that records show between June 1994 and September 1997 there was no reports regarding this family.

- **February 12, 1991**. Report of Child Neglect. Outcome: some investigation, consistent with the practice of the time.
- **March 7, 1991**. Report of Physical and Emotional Abuse. Outcome: family service file is opened.
- **May 14, 1991**. Report of child neglect. Family services file still open.
- **September 9, 1991**. Request for service. Outcome: Family service file is closed after providing food vouchers without a reassessment of risk conducted.
- **September 3, 1992**. Report of neglect. Outcome: not investigated
- **April 6, 1993**. Report of Neglect. Outcome: minimum investigation
- **April 11, 1993**. Report of Neglect. Outcome: report is considered supplemental and not investigated.
- **April 14, 1993**. Report of Neglect. Outcome: minimum investigation.
- **April 16, 1993**. Report of Neglect. Outcome: this report is considered additional and supplemental; not investigated.
- **May 18, 1993**. Report of neglect. Outcome: not investigated
- **May 27, 1993**. Report of Neglect. Outcome: not investigated
- **June 3, 1993**. Family Support Services. Outcome: Suspected sexual abuse, custody issues, possible anaemia, and neglect. Child was examined medically with no findings. No investigation.
- **July 6, 1993**. Report of neglect. Outcome: minimum investigation.
- **August 5, 1993**. Report of neglect. Outcome: minimum investigation.
- **June 27, 1994.** Report of neglect. Outcome: minimum investigation.

Between June 1994 and September 1997 there are no reports or contacts. The family's whereabouts between these years is not known. The child welfare history continued in 1997.

- **September 10, 1997**. Report of neglect and physical harm. Outcome: this report was made by the school to MCFD. This report was accepted for child protection investigation and assigned a 24 hour response time, per policy. This file was still open with no further action when the next report was received a year later. Ms. Morrison testified that the child in question was interviewed on September 16, and the report passed to another case worker to complete. The social worker could not remember why the report was passed on. Services were offered to the mother. There was no evidence from the mother that she could not address the concerns.

- **September 1, 1998**. File was audited as part of regional audit and identified as requiring priority follow up. (Between September and December 1998, all the Prince George Child, Family and Community Service cases were audited)[2].

[2] The audits identified a number of practice issues including the identification of some caseloads that had been minimally managed. As part of the response, all caseloads were reviewed and the outstanding work was prioritised for completion.

- **September 21, 1998**. Report of Emotional Abuse and Neglect. Outcome: The report was entered into the system and the 1997 file found still open with no investigation. The worker assigned to the file in 1997 had since left the Ministry. A review of prior contacts was done and a new file opened and transferred to the same social worker previously involved. This report was not investigated.

- **February 15, 1999.** This file was reviewed and collateral information gathered from the Child Development Centre (CDC), the RCMP, and the school. The teachers and CDC staff had no concerns. The RCMP had taken over the common assault complaint of September 1997.

- **March 1, 1999.** A social worker arrived to do an unannounced home visit. The SW reported there was food in the home, the home was clean and tidy, there was emergency contact information taped on the fridge and the children were looking well. The file was closed.

Next to testify was the Child Development Centre supervisor Julia Lamming.

The CDC provided services for children in rehabilitation and therapy services, Early Education, a preschool program and support services. The children attended all day and every week day.

Ms. Lamming testified that the Simpson girls all attended the preschool program at one time. They received developmental support in the physical and marginal group. The two older girls at eight and six years of age when Amanda died had graduated to the 'in school' support services. Amanda and her younger sister attended the CDC daily at the time of her death.

- **In March 1999,** CDC staff made a report of concern to MCFD. The youngest girl had exhibited a marked change in behaviour. She had chronic cold sores. She demonstrated binge eating behaviour, hoarding toys or packing them around and not wanting to give them up. She demonstrated lots of sadness; an inability to relax and flailing. Coroner's Counsel asked Ms Lamming's opinion of this change in behaviour and she testified that it could indicate a number of things, but that it absolutely indicated some kind of distress. Ms. Lamming testified that this behaviour continued.

- **March 14, 1999.** Mr. Bird was next to testify as the child protection intake worker at MCFD during 1998 and 1999. Mr. Bird testified that late in the afternoon of March 14 CDC staff made a report of suspected physical abuse. The report indicated 12 days before, one of the Simpson girls had reported that Mr. Polson had hit Amanda. Mr. Bird testified that he went to the school the next day and interviewed the two girls in school. He then went to the CDC and interviewed the two Simpson girls

there. The girls reported being spanked, having their mouths washed out with soap and spousal fighting. Following the interviews with the girls he went to the residence and interviewed their mother.

Mr. Bird testified that the mother denied the stories and stated that she had not seen Mr. Polson spank the girls or use soap in the mouth. She confirmed she used to spank and now only used time out as that was more effective. She denied spousal fights with Mr. Polson, and referred to her ex husband as the spouse involved in fights with her. Mr. Polson was not at the residence, nor was he at any time interviewed.

Mr. Bird testified the CDC staff made a new report the next day as they had noticed a suspicious bruise on the inside of the youngest child's upper thigh during a diaper change. The staff also reported it to the mother. She tried to get an immediate medical exam but was unable to see a physician for almost two weeks. The physician she did eventually see found no sign of physical abuse. The family received a recommendation for the girls to attend a group for 'children who witness violence'. An Immediate Safety Assessment was completed and the children deemed safe. The file was closed in April 1999.

- **May 11 1999.** MCFD received a call from the school. One of the Simpson girls had told her teacher that she was afraid she was going to be beaten up by her mother with a hairbrush. Mr. Bird testified that he went to the school right away and interviewed the child. He testified she told him things were not good at home and that she was blamed for everything.

He testified that he went to the home to see the mother right after leaving the school but there was nobody home. He spoke with the mother on the phone later that day. The mother denied hitting her daughter. Mr. Bird stated that based on previous involvement and conclusions he assessed the child was not in immediate danger and the file was closed.

Mr. Bird testified that at this time in Prince George there were six child protection workers and there were 180 case files. They only had time to focus on the most critical and overt cases of child endangerment. He testified that had the time been available, more things could have been done.

- **June 21 1999**, a CDC staff member reported a questionable abrasion to the genital area on the younger child during a diaper change, and bruising to her back. Mr. Bird testified that very quickly he arranged for a medical examination at the Northern Child and Family Clinic. Dr. Hay examined the girl on June 23rd and determined there was no traumatic injury and the abrasion was likely due to chaffing from infrequent diaper changes, and the story about the bruising was consistent with the bruise pattern.

- **June 22, 1999.** A new SW took this report and interviewed the sisters. The information was the same as in previous interviews although this SW noted that it appeared more positive. The SW then spoke to th

CDC staff; they confirmed they had no concerns regarding the care of the girls by the mother. They told the SW that the youngest was still exhibiting regressed behaviours. The mother was referred to support services.

- **June 28, 1999.** Mr. Bird testified that the SW met with the mother and had a discussion about physical interaction in the home. The family was again referred to support services.

- **July 7, 1999.** The two younger girls were examined again. No new concerns had been raised. The file was closed. Mr. Bird testified that relative to other cases being held at that time, he did not identify any issues sufficient to indicate he should be more assertive.

- **September 10, 1999.** School counselor reported possible neglect. SW (not Mr. Bird) attended the school and interviewed the child on September 11, 1999.

- **October 8, 1999.** School report to MCFD that child afraid to go home but complaining of feeling unwell. SW attended and interviewed the girls at school. No cause for concern reported to school.

- **October 29, 1999.** School report to MCFD that child arrived in breakfast room crying and afraid and asked for help.

The jurors questioned Mr. Bird about how prevalent inconsistencies are in the information provided by children and their parents, and did he feel it would have been helpful to have interviewed Mr. Polson. Mr. Bird testified it may well have been helpful. He testified that the sad reality in 1999 was the overwhelming case loads. The six child protection workers were forced to pick and choose between cases to investigate, some of which were life threatening cases. He testified that ideally they would have interviewed all the collaterals and conducted repeat interviews. The standard was to check all child carers in the home. That was not possible in 1999.

Mr. Bird testified that the unfortunate thing is you can create standards but it is not practical if operationally you can not meet those standards. This was the situation in 1999. He was asked by a juror what a perfect world would look like. Mr. Bird testified that it would be better to have two social workers to a team, one male and one female; to increase the level of contact with families that are frequently reported; the Act says 'safety and wellbeing' and in Mr. Bird's opinion the child welfare services lack the well being part and they only look at the safety aspect. He testified that regressive behaviour attributed to the youngest child is a 'red flag'. A multi disciplinary assessment would have been helpful. It would necessitate increasing staff and increasing expertise. Mr. Bird testified he is no longer a child protection worker because he could not do an adequate job with the limited resources and limited support of the time.

Next to testify was the school Youth Care Worker Ms. Olexyn. She testified that on October 29, 1999, one of the girls arrived at the breakfast room crying and asking her for help and to please save them. She testified the child told her she was afraid and her finger was hurt by her dad. The school report of the incident was entered as an exhibit. The report notes that Ms. Olexyn examined the finger and it was red and puffy. Ms. Olexyn asked the child what happened and she replied that her dad had hit her and she was scared. She testified that the reporting child's sister came over and told her the story was not true.

Ms. Olexyn testified that after consulting with other staff at the school she called MCFD and reported the incident to the same SW who dealt with the report of October 8, 1999. She followed up the phone report with a written report via fax. Coroner's Counsel asked Ms. Olexyn if this was a usual occurrence at the school. She testified that their school is an inner city school and therefore they deal with more high risk incidents as a result. Coroner's Counsel asked if her main concern that morning was the child reporting the hurt hand, and she replied yes. She testified that the school had not received any prior history on the family from MCFD.

Ms. Olexyn testified the social worker indicated she would not be responding to this report as in her opinion the reporting child was not credible and had problems with truth and fiction. The SW advised Ms. Olexyn to report the story to the parents and refer the child to the school counselor for work around truth and fiction. Ms. Olexyn stated that she discussed the conversation with the principal and other staff. They decided not to report the child's disclosure to the parent but to document the discussion with the SW along with a formal report to MCFD.

Ms. Olexyn testified, in answer to a juror's question, that in her opinion she believed there was truth to what the child said, and that the other sister was the mothering kind and would protect her sisters. When asked if she was happy with the decision the SW made, Ms. Olexyn replied, no. She testified that she spoke to the principal about her concern and a school based team meeting was held to discuss those concerns. The team consisted of the Principal, the Vice Principal, the counselor, Aboriginal worker, and Youth Care worker. They decided to carefully document the recent concerns, actions, and interactions with the Simpson girls and MCFD.

The social worker who took the October calls appeared next. She testified that she took the October 8, 1999, intake. She added that front line workers, as she was then, did not make decisions by themselves. The decision is signed off by a supervisor. In referring to her file she noted the last assessment before October 8 1999 that was signed off in relation to the Simpson family was in July 1999.

Coroner's Counsel directed Ms Quesnel, the SW, to the report of October 8, 1999. Ms. Quesnel testified that she interviewed the child and described her as being 'off the wall'. It was the Principal's birthday and Ms Quesnel felt this was probably a good reason the child didn't want to go home, not because she was scared of

beating. Ms. Quesnel testified that she asked the child what she had for supper and the child changed her answer each time she was asked. She testified that after that interview she spoke briefly with the teacher and school counselor. She also spoke to the older sister and found her thoughtful. She asked the older sister about the discipline in the home and was told they received time out. She stated the second child was difficult to interview.

Ms. Quesnel testified that she went to the girl's home unannounced to interview the mother and arrived just as the mother was arriving home with the two younger girls from the CDC. She informed the mother of the report that she had physically abused her daughter with a hair brush. The mother denied this had happened. Ms Quesnel stated that she told the mother she did not think the girls were at risk. Ms. Quesnel did not go in the residence; she spoke to the mother outside the home.

Ms. Quesnel returned to her office and testified she completed an immediate safety assessment report and concluded the children were not at risk. Ms. Quesnel wanted to speak to her supervisor for advice whether she should follow up on standards. She testified the supervisor told her she did not need to at that time. A letter was sent to the mother advising there would be no further MCFD action.

Ms. Quesnel testified that she made a note on the file that the reporting child told stories and noted her opinion questioning whether MCFD needed to continue responding to this family in the same way. She testified that it was not up to her whether that needed to be looked at, but that was her train of thought. Ms. Quesnel testified that at this time she had agreed verbally to take over as Acting Team Leader in her office and therefore supervising herself as a field worker as the Ministry was short of delegated social workers. As a Team Leader she would not usually take call and act as a field worker, but at this particular time she was doing both. When asked if she thought of going to interview the child again Ms. Quesnel testified that if she had she would have got the same stories.

She testified that in responding to a report there are four response priorities: 1 is immediate: 2 is a threat of serious physical abuse and that has a 24 hour response time limit: 3 is a moderate threat of abuse with a five day response time and 4 is a likelihood of abuse with a five day response time limit. Ms. Quesnel was asked if she had put a priority level on the Simpson file, and she stated she had not. She was asked if she ever discussed this with her supervisor, she testified she did not.

Prince George RCMP Corporal, M. Stevenson, next testified that the home was examined October 31st 1999, and photographs taken. A series of photographs of the residence taken that night and floor plans were entered as exhibits. The images of the residence depicted a home readied for Halloween and images of the girls' bedroom with the bunk beds, the split stairway and landing, and the bathroom and kitchen.

Cpl. Stevenson confirmed Mr. Polson was taken for a breathalyser 7 hours after taking Amanda to the hospital. His blood alcohol at that time was 0.02%, (at the rate of .02% metabolized over one hour the level at the time Amanda was taken to the hospital would have been ± 0.14%).

Cpl. Stevenson testified that a report went to crown when their investigation was completed. A reply was received back in February 2004 informing them that charges would not be approved.

The last testimony came from Mr. Robert Watts, the Regional Director of Child Welfare. His testimony covered the changes and improvements that have occurred within MCFD and specifically child welfare since 1999. He first identified the DCR recommendations.

The MCFD Director's Case Review's thirteen recommendations

1. The Regional Executive Director ensure that all child protection workers and supervisors re-attend the child protection investigative training programme and risk assessment training programme within 9(days.
2. The MCF Training Branch is to coordinate the required investigative training and risk management training in Prince George within 90 days.
3. The Regional Executive Director immediately ensures that the Regional Child Abuse Consultant is not assigned to cover supervisory vacancies unless their position is adequately backfilled.
4. The Regional Executive Director ensure that that the Regional Child Protection Manager advises all child protection workers and supervisors of the requirement for immediate case consultation, including when consultation should be sought, where case consultation is available and how it may be accessed. A copy of this direction to staff is to be provided to the Director's office within 14 days.
5. The Regional Executive Director ensure that the MCF protocol with the school board be amended to include direction for who to contact in MCF when school personnel disagree with the MCF response to a child protection report.
6. The Regional Child Protection Manager initiates and establishes a series of regular child protection practice forums and these forums are used to keep staff up to date on child protection practice and to continue to develop child protection knowledge and skills.
7. Regional Child Protection Manager immediately discuss with all child protection staff the practice standards respecting child protection reports and investigations, case consultation, and reporting to the police.
8. The Regional Executive Director ensure that there is a written protocol developed between MCF and the RCMP and that staff are advised of the requirement to report cases of child abuse to the police. A copy of this protocol is to be provided to the Director's office within 30 days

9. The Regional Executive Director ensures that all acting supervisors are advised of their sign off requirements prior to assuming acting supervisory duties.
10. MCF commit funding in fiscal 2000/01 to support the establishment of SCAN (Suspected Child Abuse and Neglect) team in Prince George for the purpose of providing expert medical assessment of abuse/neglected children and children at risk of abuse/neglect.
11. The Assistant Deputy Minister of Regional Operations in consultations with the Regional Executive Director considers the establishment of an additional supervisory position and an additional child protection consultant position in the Northern Interior Region, Prince George office.
12. The Assistant Deputy Minister of Regional Operations ensures that the Northern Hiring Strategy is given priority implementation status. The Director of the Child Protection Division review with the Director of Systems the issues related to documentation restrictions within the MCF SWISMIS electronic case management system.

Mr. Watts' testimony confirmed that all the recommendations were implemented and signed off as complete by June 25th 2003.

Mr. Watts provided examples of change such as in the role and capacity of acting supervisors or Team Leaders. In 1999 there were seven Team Leaders in Prince George for the seven offices in Prince George. They were responsible for intake reports in addition to their guardianship function, their resource function, i.e. foster homes, and adoption function. In 2007, there are 9 Team Leaders in Prince George. Mr. Watts testified that the number of children in care (1200) and the number of reports received (80,000) in the Northern Region in a given year are unchanged, but now they have increased their capacity to track cases, and the ability to expand the safety net for families. In addition they have implemented a position of Supervisor to the Supervisors to allow for an overall increase in capacity for consultation in the region.

Mr. Watts testified that in the last 5 years he has seen an increase in the ability of the Ministry in the north to work with these families. An example of this he gave was in the matter of dispute resolution. MCFD now hold family group conferencing. This may involve the temporary removal of a child while the Ministry works with the parents. Mr. Watts testified that the focus of the system has changed; the better way is to bring more people to the table and involve them all in any safety plan for 'at risk' children. His belief, based on his experience, is that a better way to look after children identified at risk is with the extended family members; that increased consultation is more willing to involve family, friends and community to help support our vulnerable 'at risk' children.

This concluded witness testimony.

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

SIMPSON	AMANDA JEAN
SURNAME	GIVEN NAMES

Pursuant to Section 3(2) (d) 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:

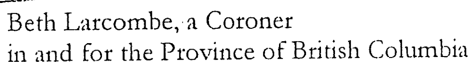
RECOMMENDATIONS OF THE JURY

To: Mr. Terry Smith
Chief Coroner
Metrotower II Suite 2035
4720 Kingsway Street
Burnaby BC V5H 4N2

1. To hold a coroner's inquest regarding a questionable death in a timely manner.

To: Honourable T. Christensen
Minister
Ministry of Children and Family Development
PO Box 9057 Stn Prov Govt
Victoria BC V8W 9E2

2. Form focus groups for all MCFD offices in BC, comprised of pertinent partners such as; the RCMP, school counselors, daycare workers, etc., to evaluate the performance of each MCFD office, with a mandatory action plan from the designated director to address any concerns listed, in a timely manner.
3. Continuous upgrading/training for all case workers, team leaders, directors, etc., in the MCFD regarding child protection, interviewing, investigation, and risk assessment.
4. Review monies allocated to the MCFD to increase resources aimed at child protection.



Beth Larcombe, a Coroner
in and for the Province of British Columbia