CORONER'S COURT OF BRITISH COLUMBIA

held at TERRACE, British Columbia

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on June 18, 2007 a Terrace, British Columbia, and continued on the following dates June 19-20, 2007 into the death of Rowen Von Niederhausern find that he came to his death at approximately 0845 hour on the 16th day of August ,2002 AD, ______ at or near Terrace ,British Columbi

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death:	a) Diffuse cerebral edema.
	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 20th day of June AD, 2007.

MARJ PAONESSA
Presiding Coroner's Printed Name

M Paonessa
Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age:	14 months	Gender:	☒ Male	☐ Female	
Date of Birth:	4 June, 2001	Native:	☐ Yes	☒ No	
Coroner's Case No.:	2002-692-0019	Post Mortem:	☒ Full	☐ External	☐ None
Police File No.:	02-7185	Toxicology:	☒ Yes	☐ No	
Police Department:	Terrace RCMP	Identification Method:	☒ Visual	☐ Other	(specify below)
Court Reporter:	Verbatim Words West	Identified by:	Family member		
Phone:	604-591-6677	Premise of Injury:	Private Residence		
		Premise of Death:	Private Residence		

INQUEST PROCEEDINGS

The inquest into the death of Rowen Von Niederhausern commenced at 0930 hours on June 18, 2007 at Terrace Courthouse. The inquest continued on June 19-20, 2007. Mr. Mike Shaw was counsel to the coroner. Ms. Judith Kenacan represented Ms. Bonnie Von Niederhausern, Ms. Suzette Narbonne represented Mr. Mark Von Niederhausern and Mr. Richard Meyer represented the Ministry of Children and Family Development. Deputy Sheriff Dave Horvath took charge of the Jury and recorded the following exhibits:

1) Registration of Death, Rowen Edwin Russell Von Niederhausern;
2) Series of nine photographs depicting the Von Niederhausern residence;
3) RCMP videotape footage of outside and inside of Von Niederhausern residence, August 16, 2002;
4) Final Postmortem Report, Rowen Von Niederhausern;
5) RCMP Toxicology Report, Rowen Von Niederhausern;
6) Curriculum vitae, Dr. Carole Jenny, Hasbro Children's Hospital, Providence, Rhode Island;
7) Mills Memorial Hospital emergency room record, August 16, 2002.

The following witnesses gave evidence:

1) Ms. Heidi Von Niederhausern, paternal grandmother
2) Ms. Bonnie Von Niederhausern, mother
3) Mr. Mark Von Niederhausern, father
4) Mr. Clint Bindon, BC Ambulance
5) Mr. Brian Correia, BC Ambulance
6) Dr. Jennifer Rice, forensic pathologist
7) Dr. Jean Hlady, pediatrician, BC Children's Hospital
8) Dr. Carole Jenny, pediatric trauma expert, Hasbro Children's Hospital, Rhode Island
9) Mr. Thomas Stark, neighbour
10) Ms. Gilberte Rioux, neighbour
11) Dr. Fourie, emergency physician, Mills Memorial Hospital
12) Dr. A. Adlam, pediatrician
13) Ms. Elaine Pigeau, RN, Mills Memorial Hospital
14) Ms. Miki Smart, social worker
15) Dr. Chkipov, family physician
16) Mr. Robert Watts, Director of Child Welfare, North Region, MCFD
17) Ms. Twyla Knutson, social worker, MCFD
18) Cst. B. Lofroth, Terrace RCMP
19) Sgt. R. Hardy, Prince George RCMP

PRESIDING CORONER'S COMMENTS

The following is a brief synopsis of the evidence presented at this 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.

The Jury heard evidence that Rowen Von Niederhausern was a 14 month old child who resided with his parents and an older sibling in Terrace. Rowen's parents both reported that he had suffered from colic for the first year. More recently, he had been irritable due to teething. He visited the family physician nine days prior to his death for scheduled vaccinations after which his parents reported he was fussy and irritable. There were no other significant medical conditions.

Ministry of Children and Family Development (MCFD) first became involved with Rowen's mother in the mid 90's which resulted in her receiving a variety of support services including treatment for ongoing depression and several years of counselling for Post Traumatic Stress Disorder. She subsequently moved to Terrace and began a relationship with Mr. Mark Von Niederhausern.

The Ministry became involved again when Rowen's older sibling was born in 1999. A Parental Capacity Assessment was completed at that time which indicated that the parents did not present a risk of abuse to their children, but that they may not self report when they were not coping well with stressors. The family was, however, able to meet all conditions set out by the MCFD's supervision order and their file was closed in February of 2001. Mrs. Von Niederhausern continued to receive treatment for persistent migraines, gallbladder problems and a recent incident of partial paralysis. .

Rowen was born in June of 2001. He was a few weeks premature and had respiratory difficulties which resulted in his transfer to BC Children's Hospital for treatment. His breathing difficulties resolved and he was reported to be thriving by his family physician who last saw him in May of 2002 for an ear infection. There was never any indication of abuse or neglect observed by the family physician.

In June of 2002, MCFD was contacted by a neighbour who reported observing a small child hanging out an open window at the Von Niederhausern residence. There was also a concern that a child had been crying a lot and the Hibachi BBQ was left unattended while the young child was in the yard.

MCFD social worker Twyla Knutson was assigned this file and spoke to her supervisor who was aware of the family. She was advised about the mother's remote history with the Ministry as well as the matters surrounding the Ministry's involvement in 1999 with Rowen's older sibling. She was made aware that a

Parental Capacity Assessment had been conducted on this family in 1999 and would have been familiar with the findings which indicated that the Ministry had concerns about the parents' ability to cope with stressors.

Ms. Knutson arrived at the residence unannounced and discussed the neighbour's concerns with the parents. She was told that Rowen was fussing and had a sore throat recently. During her visit a pot was left on the stove causing a lot of smoke. She also suggested the parents acquire further smoke detectors for their residence and address the safety issues regarding the children having access to the window and the BBQ. Ms. Knutson recalls having a conversation with the parents about how they were coping with stress and what supports they had.. She said they seemed to understand the concern and expressed to her that they were doing well. Ms. Knutson returned to the residence in a few weeks and noted that the family had followed through with all of her suggestions. She did not note any concerns about neglect or abuse with either of the children. She stated that the trailer was very cluttered but not to the extent that she viewed in the photographs taken by police on the day of Rowen's death. After a further discussion with her supervisor, the file was closed shortly thereafter.

In the late afternoon hours of August 15, 2002, the family was invited over for dinner at Mr. Von Niederhausern's mother's home. Rowen's mother had just returned from Prince George where she had received a variety of medical tests for her continued health issues. She declined to go for dinner, but her husband attended with the two children. His mother described him as a good father who was very gentle with the children. Nothing out of the ordinary was noted with Rowen that evening and the family returned home at approximately 1900 hours. The children were prepared for bed and eventually they were both settled in their respective beds. Rowen awoke a short while later and his father retrieved him from his crib and took him to the living room to sleep with him in order to allow his wife to get some rest. He stated that he was lying on the couch on his back with Rowen placed face up on his chest. Rowen's father stated that he had done this a number of times before with Rowen to settle him back to sleep. He told the Jury he suffers from narcolepsy and that he sleeps very deeply.

Mr. Von Niederhausern next remembers being awakened at approximately 0200 hours because Rowen was awake and had wet his diaper causing his shirt to become wet. He said he changed Rowen's diaper and put him in clean clothes. He said Rowen was wide awake so he prepared a bottle for him to help settle him. About an hour later, Rowen went back to sleep. His father next remembers being awakened by the older child who was coming down the hall banging on the walls. He realized that the sibling needed to be changed so he slipped out from under Rowen, whom he believed to be sleeping, and went to run a tub. He told the Jury that he had a "funny feeling" something was wrong with Rowen so he drained the tub and went back to the living room. He said that Rowen was still lying on his back on the couch in the same position and he was not breathing. He picked up Rowen and called out to his wife that he wasn't breathing. His wife started to do CPR while he called 911. He was advised by the dispatcher to place the child on the floor so he brought Rowen back out to the living room and followed the directions until the EHS paramedics arrived.

Two ambulance crews responded to the Code 3 call to the Von Niederhausern residence. They arrived to find Rowen on the living room floor with CPR underway by his father. Mr. Bindon, a senior paramedic noted that Rowen's lips and limbs were cyanotic. He was not breathing and there was difficulty in getting an airway placed. Mr. Bindon felt that this might have been due to some kind of obstruction. He noted that Rowen did not have any apparent marks or injury and appeared to be well nourished. Rowen was subsequently transferred to hospital, where physicians were awaiting his arrival. Mr. Bindon passed along his concern about an airway obstruction to one of the physicians. A portable X-ray was subsequently ordered but did not identify any significant obstruction. Emergency physicians took over resuscitative efforts at the hospital. Despite aggressive attempts for approximately 45 minutes, no response was noted and Rowen was pronounced dead at 1015 hours.

The physicians and staff at the hospital commented that Rowen appeared to be healthy and well nourished with no outward marks of injury. Ambulance paramedics and hospital staff all noted a lack of emotional reaction on the part of Rowen's father. Mr. Von Niederhausern testified at the inquest that it was his nature and upbringing which causes him to show little emotion in public. He told the Jury that he did later break down privately with family grieving the death of his son.

A postmortem examination was conducted by forensic pathologist Dr. Jennifer Rice who reported no outward signs of injury on Rowen's body. Her examination internally did not identify any natural disease or trauma to cause or accelerate Rowen's death. The principal finding, following microscopic and toxicology studies, was that of diffuse cerebral edema with no noted underlying etiology.

Dr. Rice documented that while the classic signs and symptoms of Shaken Baby Syndrome (also known as Abusive Head Trauma) were not present, the diffuse cerebral edema was in and of itself significant enough to cause death. She told the Jury that the swelling could have been caused by a single episode of aggressive shaking even in the absence of other findings suggestive of injury, such as bruising on the back, retinal hemorrhages, trauma to the brainstem or fracturing of ribs, skull or long bones.

Dr. Rice's forensic examination did not include a microscopic examination of the brain stem or a full skeletal X-ray survey as she was satisfied that there was no evidence of hemorrhage or injury on her gross examination. The Jury heard evidence that enucleation (removal) of the eyes during an autopsy examination allows the pathologist to identify retinal hemorrhages behind the eye and along the optic nerve that are indicative of an aggressive shaking injury. Dr. Rice did not remove the eyes for further examination in this case as she was aware that the child had undergone prolonged resuscitation efforts which could also result in petechial hemorrhaging within the eyes. Both Dr. Hlady and Dr. Jenny advised the Jury, however, that the retinal hemorrhaging can be readily differentiated between the two actions.

Dr. Jenny further suggested that special histology stains can assist the pathologist in examining the brainstem which can detect microscopic hemorrhaging into the tissue that is caused by a shaking incident. She told the Jury that the brainstem and high cervical cord are more exposed and vulnerable in a child and needs to be examined carefully to identify bleeding not seen with the naked eye. Dr. Jenny commented on the overall completeness of the autopsy report and suggested that all forensic pathologists performing autopsies on suspected child abuse cases should:

- include a full skeletal X-ray survey to identify any occult fractures not seen clinically;
- conduct a thorough microscopic brainstem and high cervical cord examination, and
- conduct a complete examination of the eyes by way of enucleation to determine if any retinal hemorrhages are present.

Dr. Jenny testified that a single episode of aggressive shaking could create a progression of symptoms in a child ranging from halting breaths, lethargy, drowsiness and unconsciousness that can develop over a period of hours. She indicated that the timeline of events leading up to Rowen's death would be consistent with an incident of shaking occurring in the early morning hours of August 16, 2002.

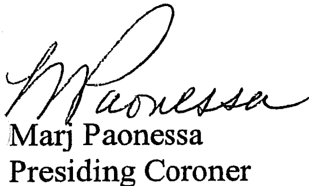
The RCMP conducted a lengthy investigation into these circumstances which included interviews with both parents. At one point in his second statement to Cst. Bruce Lofroth, Mr. Von Niederhausern stated that due to accumulating fatigue and frustration, he may have shaken Rowen when he was awakened in the early morning hours of August 16, 2002. He was provided with a doll during his interview and demonstrated for the officer how he may have shaken Rowen. Mr. Von Niederhausern advised this Jury that he was tired, confused and hungry during his lengthy interview which is why he told the police he shook Rowen. It was his evidence at the Inquest, however, that he did not, nor had he ever shaken Rowen.

The police file was subsequently forwarded to Regional Crown Counsel as part of their investigative process and it was determined that no criminal charges would be put forthcoming in this case.

The Jury was told about a MCFD tool known as a Comprehensive Risk Assessment (CRA). This assessment tool assists social workers during an investigation to ensure that specific areas of concern are addressed to ensure a child's safety is being managed appropriately. The CRA is reviewed and updated as new information comes in on a file. In this case, the CRA was completed when the decision was made to close the family service file in early 2001. The family was not contacted and significant collateral information was not included in the CRA. The only followup comment noted was that if Mrs. Von Niederhausern ever became a sole provider for her child, that the social worker should do a further assessment.

Since 2002, a significant amount of effort has been made by the Ministry to ensure that social workers are aware of the importance of considering a number of factors to ensure the welfare of a child. This includes working with universities to offer a child welfare specialty component and practicum within the social work degree programs. The new social workers will work with an experienced child protection worker who mentors them to understand history patterns which may predict future incidents within a family. Since 1999, the ratio of supervisors to Team Leaders has increased so that workers have more time for consultations and clinical support in managing their caseloads.

At the end of their deliberations, the Jury classified this death as accidental and put forward the following recommendations to the Office of the Chief Coroner for dissemination.



Marj Paonessa
Presiding Coroner

CORONER'S COURT OF BRITISH COLUMBIA

held at Terrace, British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

VON NIEDERHAUSERN	ROWEN
SURNAME	GIVEN NAMES

JURY RECOMMENDATIONS

To: Mr. Terry Smith
Chief Coroner
Metrotower II
#2035 – 4720 Kingsway
Burnaby, BC V5H 4N2

1. Establish protocols for mandatory head to toe testing during autopsy following the unexplained death of any child. Update said protocols as new technology becomes available.

   (Background Information – the Jury heard evidence from Dr. Carole Jenny that a standardized policy for forensic pathologists performing postmortem examinations on suspected child abuse cases should be adopted in British Columbia. This policy should stress the necessity of eye enucleation for the examination of retinal hemorrhages, the need for a thorough microscopic examination of the brainstem and the need for a complete skeletal X-ray survey to be conducted in each case.)

To: Honourable Tom Christensen
Ministry of Children and Family Development
PO Box 9057
STN PROV GOVT
Victoria BC V8W 9E2

2. When enough flags have been raised regarding a family situation, the file should remain open and periodic checks continue for several years.