BRITISH COLUMBIA

CORONER'S COURT OF BRITISH COLUMBIA

held at FORT ST. JAMES, British Columbia

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 10th October 2007 at Fort St. James, British Columbia, and continued on the following dates 11th and 12th October 2007 into the death of Serena Leona Marie Wiebe find she came to her death at approximately 0400 hours, on the 17th day of June AD, 2005 at or near Fort St. James, British Columbia.

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) Undetermined

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 12th day of October AD, 2007.

TONIA GRACE
Presiding Coroner's Printed Name

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age:	6 months	Gender:	☐ Male	☒ Female	
Date of Birth:	22 November 2004	Native:	☒ Yes	☐ No	
Coroner's Case No.:	2005-0664-0009	Post Mortem:	☒ Full	☐ External	☐ None
Police File No.:	2005-1801	Toxicology:	☒ Yes	☐ No	
Police Department:	Fort St. James	Identification Method:	☒ Visual	☐ Other	(specify below)
Court Reporter:	Alanna Siemens	Identified by:	Mother		
Phone:	250-561-0048	Premise of Injury:	Private residence		
		Premise of Death:	Private residence		

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

WIEBE	Serena Leona Marie
SURNAME	GIVEN NAMES

INTRODUCTION

This inquest into the death of Serena Leona Marie Wiebe commenced 0930 hours on October 10, 2007, at the Fort St. James Courthouse, Fort St. James, BC, and continued on October 11 and 12, 2007. Mr. M. Houg was counsel to the coroner and Mr. R. Meyer and Ms. M. Ouellet appeared on behalf of the Attorney General of Canada (representing the Ministry of Children and Family Development). Deputy Sheriff Brett Hickey took charge of the jury and recorded the following exhibits:

1. BCAS crew report
2. Photograph (residence)
3. Photograph (residence)
4. Photograph (residence)
5. Photograph (residence)
6. Photograph (mother and child: sleeping position)
7. Notes of N. Hemstad-Leete
8. Intake report dated June 17, 2005
9. Intake report dated May 5, 2005
10. Intake report sign off dated May 3, 2005
11. Intake report sign off dated May 31, 2005
12. MCFD service standards extracts revised June 28, 2004

The following witnesses testified:

1. Cathy Allen - BC Ambulance Service paramedic
2. William McDougall - RCMP attending officer
3. Dr. Suzanne Chan - Paediatric pathologist
4. Monica Joseph - Cousin who made child protection report to MCFD
5. Arlene Goddard - MCFD guardianship worker who received initial complaint
6. Nicole Hemstad-Leete - MCFD child protection worker who processed complaint
7. Elizabeth Prince- Nezul Be Hunuyeh Child and Family Services Society worker
8. Tracy Braam - MCFD child protection social worker assigned to case
9. Renee Lebel - MCFD Fort St. James team leader
10. Shannon John - Mother
11. Hilda Schielke - Yekochee Band representative and aunt to Shannon John
12. Dr. Paul Stent - Family physician
13. Robert Watts - Director of Child Welfare (North Region)

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

WIEBE	Serena Leona Marie
SURNAME	GIVEN NAMES

PRESIDING CORONER'S COMMENTS

The following is a brief 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.

At approximately 0848 hours on June 17, 2005, the BC Ambulance Service received a 9-1-1 call for assistance at a private residence in Fort St James. Upon attending at the address provided, paramedic Cathy Allen found six-month-old Serena Leona Marie Wiebe clearly deceased in the arms of her mother, Shannon John. Ms. Allen examined the baby and found no sign of injury or trauma. She recalled that the baby's nasal passages were completely blocked by thick mucus, which in her opinion would have made it impossible for the baby to breathe through her nose.

At approximately 2200 hours on June 16, 2005, baby Serena went to sleep on her back on the couch in the living room of the residence, with her mother lying next to her. Ms. John gave evidence that she lay on her right side with her left arm around Serena to prevent the baby from falling off the couch. She stated that she woke up at approximately 0830 hours on June 17, 2005, to find Serena cold and unresponsive. She then shouted for the baby's father, Joe, who immediately went to a neighbour's home to call for 9-1-1 assistance. She said that she had last breastfed Serena just before going to sleep and that the baby had not woken up. Serena ordinarily required feeding every three-to-four hours.

Ms. John gave evidence that she consumed approximately six cans of beer during the day. Evidence was also heard that she had a sleeping pill she had received from her physician that day. Though she stated that since Serena's birth, she would smoke crack cocaine approximately once a month, she stated she had not used any crack cocaine on June 16, 2005.

The evidence of the attending RCMP officer, Constable William McDougall, was that there was no evidence of illicit drug use at the residence, though there were numerous beer cans.

The paediatric pathologist, Dr. Suzanne Chan conducted an autopsy on June 20, 2005. Baby Serena had no external injuries. The autopsy revealed no sign of disease and no cause of death. There were petechiae present on the thymus and surface of the lungs. Dr. Chan stated that one of the causes was suffocation but that there were other mechanisms that could cause this finding and such petechiae had been found in deaths attributed to sudden infant death syndrome (SIDS). She stated that SIDS was a diagnosis of exclusion after finding no cause of death following a post mortem examination, toxicology and other laboratory studies as well as reviewing the circumstances of death.

Dr. Chan noted that the baby did have some yellow/green mucus in her nose but the nasal passages were not completely blocked. She agreed that it would be possible for the baby to suffocate if just her mouth was blocked. The toxicology tests were negative. She concluded by saying that there was no anatomic or toxicological cause of death and that, but for the history of co-sleeping, she would attribute this death to SIDS. She stated that the risk of co-sleeping was that there would be overlaying compromising the baby's ability to breathe. This risk was increased by the consumption of alcohol and a sedative by the mother. She concluded that she could not, therefore, put this death into the SIDS category.

On the morning of May 2, 2005, Monica Joseph (a cousin of Ms. John) made a child protection complaint regarding Serena's care to the Ministry of Child and Family Development ("MCFD") in Prince George. Ms. Joseph gave evidence that she had received a number of telephone calls (4-5) from Ms. John on May 1, 2005. Ms. John was very upset and was grieving for the loss of a baby who had been stillborn in 2004. Ms. John told Ms. Joseph that she had been using cocaine and alcohol while caring for baby Serena. Ms. Joseph also stated she was aware that Ms. John had used cocaine and alcohol during her pregnancy, including the later stages, as were her sisters. Ms. Joseph states she had had discussed Ms. John's drug/alcohol use with Ms. John's sisters on previous occasions and they shared her concerns. This was the basis of her complaint that Ms. John was not able to properly care for baby Serena.

In May 2005, Ms. Joseph was assisting MCFD in respect of another family member and was considered a reliable source by them. She initially made the complaint to a guardianship worker she knew called Arlene Goddard. Ms. Goddard then passed along her name to a Prince George child protection worker, Nicole Hemstad-Leete together with very basic information including the name of the baby and the nature of the complaint i.e. that the baby's mother had been using cocaine and alcohol while caring for the baby. Ms. Goddard also asked Ms. Joseph to telephone the Prince George office directly. Ms. Goddard had not asked about the basis of Ms. Joseph complaint nor asked about the location of the child. It was wrongly presumed by Ms. Hemstad-Leete, having spoken with Ms. Goddard, that the child was based in Prince George. At this stage, Ms. Hemstad-Leete coded the complaint as "Further Assessment Required" ("FAR"). It was not coded as an investigation. At that time there were four choices available to her: (1) No further action (2) Offer support services (3) Further assessment required and (4) Investigation.

At approximately 1315 hours on May 2, 2005, Ms. Hemstad-Leete received a telephone call from Monica Joseph. She made handwritten notes of the complaint. She did not, in accordance with the policy guidelines, obtain any details about the basis of the complaint. She did make a handwritten note that Ms. John's sisters shared Ms. Joseph's concerns. When Ms. Hemstad-Leete entered the information into the computer system, she did not mention the concerns of the sisters and the evidence subsequently showed that the social worker who ended up dealing with this case, Tracy Braam, was unaware of this throughout her subsequent enquiries. It

seemed that the handwritten notes were eventually forwarded by house mail for inclusion of the file but it was unknown when this happened.

During the telephone conversation with Ms. Joseph, Ms. Hemstad-Leete became aware that the baby concerned was not located in her area but in Fort St James. She subsequently called the Fort St. James office and spoke with Tracy Braam, a child protection social worker. The file was then transferred to Ms. Braam. It was still coded FAR. Ms. Hemstad-Leete stated that she could not recall whether she considered changing the coding to "Investigation" after speaking with Monica Joseph. She stated that as the file was going to be transferred she would have not changed its status though if the file had remained in her office she would have discussed it with her team leader. She stated that the FAR coding was no longer an option available to social workers. They now only have the other three available to them.

Tracy Braam, a Fort St. James child protection social worker, took on responsibility for the file on the afternoon of May 2, 2005, subsequent to the phone call she received from Ms. Hemstad-Leete. She gave evidence that at that time the office had only four social workers though it was supposed to be staffed for six. She had no recollection of the telephone call and said she was basing her evidence on the computer notes she made. She had no handwritten notes. She said that the coding of FAR did not slow her down or distract her. She states she believed she took the appropriate steps and that the case required investigation, which is what she felt she then did. She gave evidence that, though she was aware that the family were living at a named local trailer park, she did not have a number. She did not consider it realistic to go to the trailer park where there were 20-30 trailers to find a woman she had never met.

After making a number of phone calls she eventually spoke to Hilda Schielke, the Yekochee Band representative and aunt to Ms. John. She was familiar with Ms. Schielke who often worked with the MCFD as the Yekochee Band representative. On May 4, 2005, Ms. Schielke gave Ms. Braam directions to Ms. John's trailer. Ms. Braam took no further action on the file that she could recall until May 11, 2005. Nothing was documented during this seven- day period. She could not recall why she had not decided to visit Ms. John until then. On May 11, 2005, she called Ms. Schielke and arranged to meet her at Ms. John's residence. She was aware that Ms. Schielke would arrive there before her. She also then arranged for Elizabeth Prince, a welfare worker with the Nezel Be Hunuyeh Child and Family Services Society to accompany her. Though Ms. John belonged to the Yekochee band that worked with the Carrier Sekani welfare agency, as they had no representatives in Fort St. James, Ms. Prince said she was happy to accompany Ms. Braam on a courtesy basis to the Sekani.

Ms. Braam and Ms. Prince attended Ms. John's home on the afternoon of May 11, 2005. Ms. Schielke was already present along with Ms. John, her common-law husband, Joe Wiebe and baby Serena. The visit lasted approximately 20-30 minutes. Ms. John denied drug and alcohol use. Ms. Schielke confirmed that she had no concerns about the baby's care. Ms. John gave evidence that she lied to Ms. Braam about her drug use, as she did not want her to take Serena away from her. She said that Ms. Schielke was unaware of her drug use. Ms. Schielke gave evidence that her daughter had told her a few months before this visit that Ms. John was using cocaine but, when she had asked Ms. John about it, she had denied it. Ms. Schielke stated she had forgotten to tell Ms. Braam about her daughter's concern.

Ms. Schielke expressed concern about the lack of local resources available to assist those who suffered with alcohol or drug problems. She told the jury that there was a very long waiting list to enter the nearest treatment centre in Prince George. She felt there was a mistrust of MCFD within the First Nations communities which though had improved in recent times, was still there.

After this visit, Ms. Braam decided to close the file without further investigation. She stated she was aware of Ms. John's history of cocaine and alcohol addiction and the fact that her older three children had been permanently placed with their paternal grandmother in 2000 as a result. She stated she had read those physical files. She decided to close the file on May 11, 2005, straight after this visit. She considered it was reasonable to close the file after this one visit. She did not gather any information after this visit. She also stated that she thought it was "pretty typical" that Ms. John did not tell her the truth about her using cocaine. She accepted that she should have contacted Ms. Joseph for further information and could not recall if she made any attempts to do so.

Ms. Braam stated that, though she did not make any computer entries about consulting with her team leader at any stage while the case was active (i.e. from May 2 until she closed the file on May 11, 2005); she believed she would have done. She could not recall any discussion with her team leader prior to deciding to close the file on May 11, 2005 and in respect of this decision made on May 11, 2005. Though she could not recall what discussions she had with her team leader, Renee Lebel, she was aware that her team leader had agreed with her decision to close the file without further investigation.

Renee Lebel confirmed that she signed off the file closure on May 30, 2005. She had no recollection of the case or her involvement in it. She could only talk as to what her standard practice was. She made no notes either handwritten or by way of computer entry. She did not consider that this complaint was subject to an investigation. She considered Ms. Braam to have been in "assessment-mode" as a result of the FAR coding. She felt Ms. Braam did not conduct an investigation. It was not coded for an investigation as it should have been. She could not specifically recall but she thought she was not in the office but away at a team leader

meeting when this complaint came into the office. She did not review the coding. She stated it was their usual practice to go back to the person reporting the concern and get more information about the basis of the complaint when there was no clarity but that had not been done in this case. She said that was not normal and she accepted responsibility for that not happening.

Dr. Paul Stent, Ms. John's family physician for the past approximate 10 years, gave evidence that during her pregnancy with Serena he had always seen her sober. Though she had admitted to him that she used cocaine and alcohol in the early part of her pregnancy while she was unaware she was pregnant, she had consistently told him she had stopped using either substance once he confirmed her pregnancy on April 28, 2004. She had suffered from depression before, during and after the pregnancy.

In January 2005, following Serena's birth on November 22, 2004, she brought the baby for her six-week check up. During that visit, Ms. John stated that she felt overwhelmed and "down in the dumps". Dr. Stent prescribed her anti-depressant medication. On May 2, 2005, (the day after Ms. Joseph said she had repeatedly been called by Ms. John who was very upset) she again attended the practice and saw a locum who refilled her antidepressant prescription and also prescribed her six sleeping tablets.

Dr. Stent next saw Ms. John on June 16, 2005 – the day before Serena was found dead. She recounted to him feelings of anxiety so he changed her prescription to a more suitable antidepressant and also prescribed some sleeping pills for her. He told her not to use alcohol when taking the medications. He also reminded her that, in any event, alcohol should not be used by those suffering from depression. He did not specifically tell her not to co-sleep with Serena though he did speak to her about the need to ensure someone else was available to care for the baby if she did not rouse. He stated that Ms. John told him she was no longer breastfeeding. The medications prescribed were not suitable for nursing mothers. It was now his practice to tell all parents not to sleep with their babies, whether taking medications or not.

Robert Watts, the director of child welfare for the North Region, gave evidence about MCFD policy. He stated that he had conducted a paper review of the case. At that time, he understood that the social worker had not considered the full file and history as it was not documented. He now understood that this had been done, though it should have been documented. His review resulted in three recommendations which had all since been implemented – these included the Community Services manager sharing the report with the staff and reviewing the need to consider history when screening and determining the correct response. In-service training was also facilitated in the area of addictions and the relationship to assessing risk for children. Finally, there was review of the area of supervision.

He stated that though Ms. Goddard had started her career in child protection, she had received no recent training in how to take a complaint of child protection. Therefore, as she was not up-to-date, the appropriate person to deal with this case was a current child protection worker such as Ms. Hemstad-Leete. There was no form used by any type of worker to ensure that all the required information was obtained in accordance with their "child and family service standard 12". It was left to the training of the worker. There was no system in place to ensure that handwritten notes taken by the child protection worker were immediately sent to the office to which the complaint had been transferred. The current system simply relied on the worker ensuring that all the relevant information was put into the computer, though the handwritten notes would eventually be sent on to join the physical file.

He confirmed that the coding "Further Assessment Required" was no longer used. It was actually discontinued in June 2005. He stated that the difficulty with the FAR coding was that it did not allow the computer to bring up the "cues" for the social worker to follow as the investigation screens did. Consequently, they were not prompted about the appropriate steps or actions to be taken. He stated that these cues assisted the social worker by walking them through the investigation to ensure that all the appropriate steps were taken. This had not happened in this case as the coding of FAR had prevented these investigational cues from being initiated. There was no software in place which allowed or provided for a supervisor, or anyone else, to check the appropriateness of codings or to otherwise oversee or approve the steps taken by the social worker. Supervision relied upon verbal consultation between the social worker and team leader.

Mr. Watts raised the concern that Ms. John had chosen not to tell the social worker about her drug use because she felt her baby would be taken away from her. Mr. Watts felt that the community needed to be educated, or be made more aware, about the role of MCFD and the support and resources that could be offered. He wanted to promote knowledge and a less adversarial approach. He felt there was a distrust of MCFD.

After deliberation the jury classified the death of Serena Leona Marie Wiebe as undetermined.

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:

.....

Tonia Grace, A Coroner
In and for the Province of British Columbia

BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

WIEBE	Serena Leona Marie
SURNAME	GIVEN NAMES

RECOMMENDATIONS OF THE JURY

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

1. That the Ministry of Children and Family Development ("MCFD") implement standardized forms (templates) as a FIRST CONTACT form requiring determination of specific information from the reporter;

2. (a) That any and all information be included in the file; and
   (b) That, in the event of a file transfer, "loose" handwritten paper be forwarded by FAX to the appropriate location;

3. Contact efforts be logged by time, date, etc explaining social worker efforts to contact client;

4. That MCFD adhere to its proactive practice by providing resources for all needs, in consultation with participating/target groups/agencies;

5. First Nation liaison/elders be given minimum formal training at least to a standard acceptable to MCFD;

6. Software be developed and utilized which provides:
   (a) a system or mechanism to reduce the possibility of wrong information or codes being entered into the computer system and
   (b) also ensures full and proper access to information;

7. Minister should make every effort to maintain Fort St James at full capacity with a team leader always on hand;

8. A face-to-face meeting between team leader and social worker before any case is closed: clear documentation of the reasons to be kept on file;

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

WIEBE	Serena Leona Marie
SURNAME	GIVEN NAMES

To: Honourable G. Abbott
Minister
Ministry of Health
1515 Blanshard Street
Victoria
BC V8W 3C8

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

9. In the spirit of cooperation, Ministry of Health and MCFD work with concerned communities to establish a alcohol/drug treatment centre within the Fort St. James area.