



CORONER'S COURT OF BRITISH COLUMBIA

VERDICT AT CORONER'S INQUEST

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

MEDICAL CAUSE OF DEATH

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

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b) Cerebral Edema

DUE TO OR AS A CONSEQUENCE OF

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

(2) Other Significant Conditions Contributing to Death:

CLASSIFICATION OF THE EVENT [] ACCIDENTAL [X] HOMICIDE [] NATURAL [] SUICIDE [] UNDETERMINED

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

SCOTT FLEMING

Presiding Coroner's Printed Name

Handwritten signature of Scott Fleming

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

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



held at Prince George, British Columbia

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FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

HALL

SURNAME

Savannah Brianna Marie

GIVEN NAMES

Pursuant to Section 39 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: The Honourable Minister: Ministry of Children and Family Development ("MCFD")

1. MCFD should improve their procedures relating to the recording and sharing of all information, relating to both substantiated and unsubstantiated allegations, which may relate to the safety and welfare of children in care.
2. MCFD should develop and implement a single document, equivalent to the "Child Services Case Snapshot", which records all allegations against a foster home.
3. MCFD should require that foster parents be trained in First Aid and CPR.
4. MCFD should revise and clarify the Standards for Foster Homes as it relates to the use of both mechanical and physical restraints. These Standards should specifically require the approval of a physician prior to their non-emergent use.
5. MCFD should revise the Supervised Visit and Transportation Record so as to require the signature of the visiting natural parent, and that a copy of the record is provided to the natural parent.
6. MCFD should require immediate notification to the applicable police agency of all serious incidents involving physical injury to children in care.



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7. MCFD should require that it be notified of all physician visits made by children in care.
8. MCFD should ensure the availability of social workers to promptly respond to and investigate allegations involving potential harm to a child in care in those situations in which the child's assigned social worker is unavailable.
9. MCFD should ensure that foster parents are provided with all available information regarding a child's history within 72 hours of placement.
10. MCFD policies should require that all resources providing service to children in care immediately report to the MCFD, and the MCFD investigate, unusual periods of absence from the resource.
11. MCFD policies should require that after hours social workers have access to information relating to the proposed foster home. Such information to include: number of children presently in care, the level of care provided by the foster home, and the history of allegations made against that foster home.
12. MCFD information management systems should track all allegations made against a foster home, including those relating to both Quality of Care and Abuse or Neglect.
13. MCFD policies should require a medical assessment before placing a special needs child in care.
14. MCFD policies should require that all social workers involved in the care of children in a foster home be provided with a copy of the Annual Review of that foster home.
15. MCFD policies should require that all allegations of Quality of Care and Abuse or Neglect be independently reviewed by workers that are not involved in the management of the foster home, or the care of children placed within that home.
16. MCFD policies should require that Guardianship workers visit each child in care on their caseload not less than twice yearly.
17. MCFD policies should require that the resource social worker review with each foster parent, at least once every five years, the then applicable Standards for Foster Homes.



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To: Executive Director: British Columbia Ambulance Service ("BCAS")

18. BCAS should modify the form of its Crew Report to allow for extra room for the recording narrative.
19. BCAS should emphasize the requirement and importance of full charting of the Crew Report by all attendants.

To: Fire Chief: City of Prince George

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

To: Executive Director: Child Development Centre of Prince George & District ("CDC")

21. CDC should revise its procedures to improve reporting and communication with the MCFD regarding children in care.
22. CDC should require notification to the MCFD of any unexplained absence of longer than two days of any child in care.
23. CDC should require the reporting to the MCFD of any observations of suspicious bruises on children in care.

To: Registrar: College of Physician & Surgeons of British Columbia ("The College")

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



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

To: The Honourable Minister: Ministry of Health ("MOH")

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

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