Report to the Minister of Justice and Solicitor General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Calgary Courts Centre

in the City (City, Town or Village) of Calgary (Name of City, Town, Village), in the Province of Alberta,

on the 1st, 2nd, 3rd day day of February, 2021 (year), (and by adjournment

on the 23rd day day of August, 2021 (year)),

before B. L. Shaw, a Provincial Court Judge,

into the death of A.J.B. (Name in Full) 23 weeks (Age)

of Calgary, Alberta (Residence) and the following findings were made:

Date and Time of Death: June 2, 2017 at 06:45

Place: Calgary, Alberta

Medical Cause of Death:

("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *The Fatality Inquiries Act*, Section 1(d)).

Undetermined.

Manner of Death:

("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *The Fatality Inquiries Act*, Section 1(h)).

Undetermined.

Circumstances under which Death occurred:

INTRODUCTION

This is a report to the Minister of Justice and Solicitor General in relation to an Inquiry conducted pursuant to the *Fatality Inquiries Act,* RSA 2000, c. F-9 into the death of A.J.B. on June 2, 2017. I am required by section 53 of the *Act* to report on the identity of the deceased, the date, place and time of death, the circumstances under which the death occurred, cause of death and manner of death. I am permitted by section 53(2) of the *Act* to make recommendations in relation to the prevention of future or similar deaths but I am prohibited by section 53(2) of the *Act* for making any findings of legal responsibility or coming to any conclusion of law.

The evidence at the inquiry was presented by Ms. Christine Nugent on behalf of Alberta Justice. The *Act* provides standing to the next of kin and the personal representative of the deceased to cross-examine witnesses and present arguments and submissions. Section 49(2)(d) of the *Act* permits other parties who claim to have a direct and substantial interest in the subject matter of the inquiry to appear with leave of the court. R.B., A.J.B.'s mother participated throughout the Fatality Inquiry without counsel. N.C., A.J.B.'s biological father had been notified of the hearing, but did not attend or participate. Further, with leave of the court, Helen Dick appeared as counsel for Alberta Health Services, Bennett Jones appeared as counsel for Dr. Mineyko (Neurologist) and Julie Hart appeared as counsel for Child and Family Services.

The inquiry heard from the following witnesses over a number of days:

(i) Ursula Hueggenberg – A.J.B.'s Foster Parent
(ii) Cst. Valois – Calgary Police Service member who responded to the scene
(iii) Farrah Bandali – Director with Alberta Health Services, Healthy Children and Families
(iv) Anna Perry – Senior Manager, Policy and Practice for Child Intervention
(v) Stacey Stradecki – Program Consultant with Child and Family Services
(vi) Jacqueline Curtis – Foster Care Worker and Licensing Officer, Child and Family Services
(vii) Dr. Edgecombe – Medical Examiner
(viii) Jody Passmore – Manager with Child and Family Services
(ix) Shelley Vandal – Placement Supervisor Response Team, Child and Family Services

Prior to the commencement of the Fatality Inquiry, I received a binder of information which was entered as Exhibit 1. Further additions were made to that Exhibit as the inquiry progressed. Exhibit 1 contained the following material:

(A) Medical Examiner's Records;
(B) Children Services Records;
(C) Alberta Health Services Records;
(D) Calgary Police Service Records;
(E) Previous Public Fatality Inquiries; and
(F) Additional records from Child and Family Services.

No other party to the Fatality Inquiry called evidence, although R.B. did provide clarification on her recollection of the contents of A.J.B.'s discharge report from the hospital.

CIRCUMSTANCES

The male infant, A.J.B. was born on December 22, 2016 to R.B. and N.C.. A.J.B. was born premature via an emergency cesarean section at 33 weeks gestation and was cared for in the Neonatal Intensive Care Unit (NICU).

On January 12, 2017 A.J.B. had a brain bleed. Medical staff believed A.J.B. would likely have ongoing medical issues and developmental needs. In the NICU A.J.B. was tube fed, as he did not have the ability to latch and swallow.

R.B. worked with a number of individuals in formulating a plan for A.J.B. Those individuals included the Youth Assessment Team (YAT), Alberta Vulnerable Infant Response Team (AVIRT), the NICU, Best Beginnings, Child and Family Services (CFS), R.B.'s Social Worker and members of R.B.'s family. Given her age, R.B. entered an Enhancement Agreement with Youth for A.J.B..

On March 7, 2017 the results of a feeding study for A.J.B. found that he did not have a gag reflux and that he did not have an ability to latch or swallow. If he were to be fed anything by mouth, he could aspirate.

On March 13, 2017 A.J.B. was discharged from the hospital to live with his mother, R.B. in a kinship setting with a supervisor from her family. Home visits were conducted by a number of organizations including CFS and AVIRT. Following concerns raised, including A.J.B.'s health care requirements an Apprehension Order was granted.

A.J.B. was placed in the foster home of Ursula Hueggenberg, where his medical needs could be met. Ms. Hueggenberg had been a pediatric nurse for 30 years, having retired 5 years prior. Ms. Hueggenberg had also been a foster parent for 21 years. As part of her employment she received training on safe sleep practices, although not through any training related to being a foster parent. In her time as a foster parent Ms. Hueggenberg would have fostered many children, including over 20 infants, only taking children with medical issues. In particular Ms. Hueggenberg had previous experience with children like A.J.B. who required tube feeding.

Between April 13, 2017 A.J.B. and May 25, 2017 A.J.B. was seen on a number of occasions by a nurse during home visits, his pediatrician and other health care professionals. A.J.B. also continued to have supervised visits with his parents.

On June 1, 2017, A.J.B. had an evaluation at the Alberta Children's Hospital to determine his swallowing ability, the test was terminated prior to completion because of A.J.B. aspirating. An oxygen test was also administered to determine how A.J.B. would react in his car seat, and there were no concerns identified.

The evening of June 1, 2017 Ms. Hueggenberg put A.J.B to bed around 6:00 pm. She placed him on his right side with a rolled-up towel on either side of him, with a blanket over the two towels so they could not move. Ms. Hueggenberg checked on A.J.B. every couple of hours. When she went to bed around 10:30-11:00 pm Ms. Hueggenberg turned A.J.B. on his other side, again positioning a rolled-up towel behind him.

In the morning of June 2, 2017 around 6:00 am Ms. Hueggenberg, found A.J.B. unresponsive in his crib. She picked him up to try and revive him, but given his state knew he passed away during the night. Ms. Hueggenberg called 911, an ambulance and the police attended.

Ms. Hueggenberg was aware that normally infants should be put on their back to sleep. The exception being where there is a medical condition that in the judgement of the medical practitioner would require a different sleeping arrangement. It was in Ms. Hueggenberg's judgement that A.J.B. could not sleep on his back because of the risk of aspiration. Ms. Hueggenberg had A.J.B. sleep in a crib 6 feet from her own bed, with his head elevated, on his side to prevent him from aspirating in his sleep.

Ms. Hueggenberg did not recall discussing the sleeping arrangement for A.J.B. with his pediatrician or any other medical professional. She felt it was obvious given his medical condition that he needed to sleep on his side with his head elevated and would not have been conformable placing him on his back.

A.J.B.'s nurse and A.J.B.'s Child and Family Services worker were aware of the sleeping arrangement for A.J.B. and the reasoning for it.

Given A.J.B. was an infant, an autopsy was conducted by the Office of the Chief Medical Examiner in Alberta. After review of the case history, autopsy findings and ancillary studies the Medical Examiner determined there were no injuries, no natural disease and no toxicological findings to account for death. The prone position of the body (unsafe sleeping position) and blanket under the face (unsafe sleeping environment) may have contributed to death.

At the time of death, A.J.B. was being investigated for possible genetic disorders as he had mild dysmorphic features and hypotonia. The Geneticist was in the process of organizing genetic testing for myotonic dystrophy and spinal muscular atrophy. In the opinion of the Medical Examiner the genetic testing would not have assisted in determining a cause of death, nor explained A.J.B.'s death.

Following the death of A.J.B. Child and Family Services conducted a review and a referral was made to the Office of the Child and Youth Advocate.

REVIEW

The death of A.J.B. is tragic. A.J.B.'s cause and manner of death are both undetermined. A.J.B. was an infant with complex medical issues who required tube feeding and aspirated easily. He was placed in the care of Ms. Hueggenberg a foster parent with 30 years experience as a pediatric nurse. Ms. Hueggenberg was aware that normally safe sleep practice requires an infant to be placed on their back, but given A.J.B.'s medical condition she felt placing him on his side with his head elevated was the only way to ensure he did not aspirate while sleeping.

Alberta Health Services, working with various partners, including Child and Family Services has had safe sleep initiatives since at least 2009, with regular updates based on new information and evidence that comes out. Child and Family Services has implemented safe sleep guidelines as part of their policy manual, requiring training and licensing of foster homes.

Although A.J.B.'s cause and manner of death is undetermined one possible issue raised by this inquiry, was infant safe sleep practices. Safe sleep practices have been recently addressed in three other fatality inquiries: the 2017 KRC Fatality Inquiry, the 2019 JJS Fatality Inquiry and the 2020 Shot Both Sides Inquiry.

In this case, the individuals involved with A.J.B. were aware of safe sleeping practices and there were policies in place regarding safe sleep practices.

Recommendations for the prevention of similar deaths:

There are no recommendations arising from this Fatality Inquiry.

DATED September 29, 2021,

at Calgary, Alberta.

Original Signed

B. L. Shaw
A Judge of the Provincial Court of Alberta