CANADA
Province of Alberta

Report to the Minister of Justice and Attorney 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 16th day of June, 2010 year, (and by adjournment

on the 17th day of June, 2010 year),

before John D. Bascom, a Provincial Court Judge,

into the death of DWL (Name in Full) (Age)

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

Date and Time of Death: October 24, 2007 at approximately 15:18 hours

Place: Alberta Children's Hospital, 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)).

Identified as DWL pursuant to s. 126.2(1) of the *Child Youth & Family Enhancement Act*. There is a ban on publication that may identify the child who has come to the Minister's or Director's attention under the *Act* or any information serving to identify the guardian of the child.

Hanging.

Dr. Sam Andrews, Assistant Chief Medical Examiner to the Province of Alberta, appointed under the *Fatality Inquiries Act,* testified that on October 25, 2007 he conducted an autopsy on the body of DWL. His conclusion as to the medical cause of death was hanging.

(Name in Full)

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)).

Accidental.

1. DWL at the time of his death was in foster care at a residence in the City of Calgary.

2. On October 24, 2007 DWL's foster mother found the child unresponsive with the cord from a set of blinds wrapped around his neck. The foster mother called EMS immediately and commenced resuscitation.

3. EMS attended and were unable to resuscitate the child. He was transported to the Alberta Children's Hospital where he was pronounced dead.

4. The deceased had been apprehended by Calgary Youth Services on September 24, 2007 and placed in foster care on October 1, 2007. At the time of DWL's death he was one of four foster children placed in the residence.

5. On the day of DWL's death the foster mother had left the basement playroom for a few minutes. DWL was with a four year old foster child in the basement playroom. A third foster child attended with the foster mother in the kitchen area of the home. According to an interview of the four year old child, DWL climbed onto something white (thought to be a window ledge approximately seven inches wide and easy to crawl up onto). DWL, according to the four year old witness, put the string from the blinds around his neck.

6. Both foster parents were experienced and conscientious. They had been foster parents since 1997 or 1998. Both parents testified that the cords for blinds in the residence were always tied up and regularly checked by the foster parents. The importance of keeping the blind cords out of reach was emphasized by the foster care worker on her regular visits to the home.

Circumstances under which Death occurred:

On October 24, 2007, at approximately 15:18 hours DWL placed the blind cord around his neck and hung himself. There is no evidence as to the condition of the blind cord at the time of the incident. Nor is there any evidence as to how DWL was able to obtain the blind cord and place it around his neck. It could be concluded that he climbed on the window ledge, obtained the blind cord, placed it around his neck and then fell from the ledge causing the strangulation.

Recommendations for the prevention of similar deaths:

During the hearing, evidence was heard from a Project Safety Officer – Health Canada, whose job was to research product safety. Health Canada regulates as well as provides informational bulletins concerning various products. Information was provided concerning recommendations Health Canada makes concerning the installation and service of blinds and in particular actions consumers may take to prevent blind cords from becoming a danger. Many blind cords are designed with a loop, which becomes a natural noose and is a specific danger to children. The court recommends that all blind cords be separated at the bottom.

DATED February 8, 2011,

at Calgary, Alberta.

John D. Bascom
A Judge of the Provincial Court of Alberta