ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Court House

in the City (City, Town or Village) of St. Albert (Name of City, Town, Village), in the Province of Alberta,

on the 29th, 30th and 31st days of May, 2017 (year), (and by adjournment

on the _____ day of _____, _____ (year)),

before Bruce R. Garriock, a Provincial Court Judge,

into the death of Shylee Kasokeo (Name in Full) 20 mos (Age)

of 8016 – 97 Street, Morinville, Alberta (Residence) and the following findings were made:

Date and Time of Death: March 2, 2010 at 16:31 hours

Place: Stollery Children's Hospital, Edmonton, 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 – *Fatality Inquiries Act*, Section 1(d)).

Undeterminable

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

Undeterminable

FORWORD:
In compliance with the *Child, Youth and Family Enhancement Act*, identifying information has been redacted, as follows:

- "G" means another foster child living at the Residence on the Day of the Incident

Circumstances under which Death occurred:

Introduction

On March 1, 2010, 20-month-old Shylee (DOB June 6, 2008) was in the care of her foster mother, Christine, at the Residence. Christine called 911 when she realized that Shylee was in distress.

EMS attended at the Residence and, after administering CPR to Shylee, transported Shylee to the Sturgeon Hospital at St. Albert, Alberta.

Later, after being airlifted to the Stollery Children's Hospital in Edmonton, Alberta, and seen by a number of medical specialists, Shylee died on March 2, 2010.

Christine was charged with manslaughter. She was tried between January 13 to February 25, 2014 and acquitted by Mme. Justice M.T. Moreau on March 19, 2014. Justice Moreau was left with a reasonable doubt as to whether Shylee died as a result of non-accidental abusive head trauma. The decision was not appealed.

Topics

- Preliminary Matters
- Exhibits
- Becoming a Foster Parent
- Shylee's Involvement in Care Prior to Being Fostered by Christine and Kirby
- Shylee being Fostered by Christine and Kirby
- Day of the Incident
- Medical Intervention
- Autopsy Report
- Dr. Ophoven's Opinion of Shylee's Death
- Case File Review of Shylee's Death
- Submissions
- Conclusion
- Recommendations for the Prevention of Similar Deaths

Throughout this Report:

- all dates are in 2010 unless otherwise indicated
- "Act" means the Fatality Inquiries Act, RSA 2000, c. F-9
- "Autopsy Report" means that autopsy report for Shylee dated June 9, signed by Sauvageau
- "Changes" means that organization contracted by the Alberta Government to provide transportation and supervision of foster care children
- "Children's Services" means the Alberta Ministry of Children's Services
- "CPR" means cardio pulmonary resuscitation

- "Day of Incident" means March 1
- "EMS" means Emergency Medical Services
- "Incident" means the distress suffered by Shylee on the Day of the Incident
- "Inquiry" means the Public Fatality Inquiry into the death of Shylee
- "Pathways" means Pathways Family Services, a foster care agency operating in Alberta
- "Residence" means 8016 - 97 Street, Morinville, Alberta, the residence of Christine and Kirby

Reference may be made to the following persons:

- "Adeagbo" means Dr. Bamidele Adeagbo, Assistant Chief Medical Examiner at Calgary, Alberta
- "Christine" means Christine Laverdiere, foster parent of Shylee
- "Dallas" means Shylee's biological mother, Dallas Lee Marie Kasokeo (aka Kahsokeo)
- "Duckett" means Mona T. Duckett, Q.C., Inquiry Counsel
- "G" means another foster child living at the Residence on the Day of the Incident
- "Harder" means Kelly Harder, an employee of Changes
- "Kaitlyn" means Kaitlyn Laverdiere, the biological child of Christine and Kirby
- "Kirby" means Kirby Laverdiere, foster parent of Shylee
- "Meadahl" means Michelle Meadahl, the Executive Director of Pathways
- "Millar" means Corey Millar, counsel for Children's Services
- "Ophoven" means Dr. Janice Ophoven, qualified as an expert witness able to give evidence in the area of forensic pathology at the trial of Christine
- "Pollock" means Matthew Pollock, Shylee's Children's Services caseworker
- "Ross" means Angela Ross, Manager of Reunification Supports for the Policy Practice and Program Development Branch and Child Intervention Division at Children's Services
- "Sauvageau" means Dr. Anny Sauvageau, Medical Examiner at the time of the Autopsy Report
- "Schrijvers" means Tammy Schrijvers, a foster parent who babysat Shylee on February 28
- "Shylee" means Shylee Kasokeo
- "Von Sprecken" means Dwayne Von Sprecken, an assessor with Children's Services
- "Weir" means Valerie Weir (now deceased), a foster care support worker

Preliminary Matters

A Pre-Inquiry Conference was held at 8:30 AM on April 3, 2017 at the Provincial Court of Alberta, 3 St. Anne Street, St. Albert, Alberta T8N 2E8. In attendance were Duckett, Millar and Judge Bruce Garriock. The following preliminary issues were addressed:

- It was decided that the Inquiry would be held for the three scheduled days of May 29 to 31, 2017, sitting each day from 9:30 AM to noon and from 1:00 PM to 4:30 PM, unless otherwise stipulated, at the St. Albert Provincial Court House.

- No objection to Judge Garriock presiding at the Inquiry was raised by either Duckett or Millar.

- The witness list attached to Duckett's letter to this Court dated May 24, 2017, was approved, subject to the following:

- Duckett was advised by former counsel for Dallas on March 23, 2017 that such counsel was no longer representing Dallas. Duckett took steps to try to locate Dallas and couriered a letter advising Dallas of the Pre-Inquiry Conference and the Inquiry to her last known address. Duckett advised that she would continue to try and locate Dallas.

- Duckett intended to produce witnesses from Children's Services and Pathways to explain their respective policies in place at the operative times of Shylee's apprehension.

- As to the pre-marked exhibit binders provided by Duckett:

  - Tab 7 will be provided in a far less redacted form;

  - When the Medical Examiner's Report is received by Duckett, it will be provided to Judge Garriock and to Millar;

  - If the apprehension of Shylee becomes an issue at the Inquiry, Millar will provide the appropriate documents from Children's Services relating to this issue in unredacted form; and

  - Duckett will tender a clean copy of the exhibit binders at the Inquiry.

- The preliminary issues facing the Inquiry were determined to be:

  1) Can the cause and manner of Shylee's death be determined with any greater certainty?

  2) Should different or additional measures have been taken in placing Shylee, in supervising or supporting the foster parents or in obtaining information after the placement?

  3) Can any recommendations be made to prevent a similar occurrence?

- Millar applied for interested party status for Human Services (aka Children's Services) under section 49(2)(d) of the *Act*. As Shylee was in the care of the Director of Children's Services at the time of her death, Millar's application was granted.

At the commencement of the Inquiry, and before evidence was heard, I advised those present of the various provisions of the *Act,* including those of section 49 and the right of interested persons to apply for standing at the Inquiry. No one indicated a desire to apply for such standing at that time.

Exhibits

Exhibits 1 to 71 were contained in three exhibit binders. A copy of indices to these binders are attached to this Report.

Becoming A Foster Parent

- **Christine**

Christine testified that in early 2010, she and Kirby were licensed and qualified as a Level 1 foster home to care for foster children after taking a number of courses. This Level 1 designation meant to Christine that she and Kirby could foster children that don't have many problems or difficulties.

- **Von Sprecken**

In March, Von Sprecken was employed by Pathways as the Supervisor and Program Manager.

Von Sprecken testified that Pathways, as a private agency, recruited and approved foster parents, and presented them to Children's Services for final approval and licensing as foster parents. Further, Pathways was the "middle person" to match a foster home with children needing foster care and provided direct support and training to foster parents.

Von Sprecken advised that Weir was the support worker for Christine and Kirby while they were foster parents. Unfortunately, Weir passed away a couple of years ago.

Von Sprecken explained that Children's Services would advise all private agencies of children requiring care. Based on this information, Christine and Kirby, being a Level 1 foster home, were offered as a match for Shylee, who was determined to be a Level 1 child. This match was then approved by Children's Services. Shylee was placed with Christine and Kirby on January 25. Von Sprecken stated that prior to this time, two foster children had been placed with Christine and Kirby, but they turned out not to be suitable matches and were removed.

Von Sprecken stated that at the time of placing Shylee with Christine and Kirby, "I think it's fair to say that we would have been trying to look for an easy child, one with not a lot of dynamics to put into the Laverdiere home."

- **Meadahl**

Meadahl, the Executive Director of Pathways since 2012, testified that in 2010 she was the business manager of Pathways. She stated that Pathways supports, recruits and assists in treating caregivers who are foster parents.

Meadahl explained that Pathways in 2010, had a contract to provide support services to foster parents within the Region (now Edmonton). Once Pathways established an available foster home, Pathways received potential placements by intake screening through the centralized intake department. If Pathways determined that it had a home that matched what the Children's Services team was seeking, Pathways put this information to the team who made its determination based on the best possible match for the child.

When a family indicated a desire to be a foster parent, they would engage with Pathways. Pathways would then start the initial stage, which is information sharing. The potential family would then attend an orientation to caregiver training. After that stage, the family would undergo a screening process, which includes a review of documents (e.g.: a criminal record check, an intervention record check and references) and they would go into a home study process.

Pathways gathered all of the pertinent documents and completed the home assessment, and then forwarded them to the Children's Services. Thereafter, Pathways would receive word back from the intake team at Children's Services that the family had been approved or not as a foster home. Once the license was in place, Pathways was able to place a child with the foster parents.

Meadahl stated that Pathways' policy was to have children seen by doctor within the first 10 days after placement with the foster parents.

- **Ross**

In 2010, Ross testified that she was a Program Consultant with the Policy, Practice and Program Development Branch and Child Intervention Division at Alberta Children's Services (currently she is the Manager of Reunification Supports for this Program).

Ross referred to Exhibit 65, which contains excerpts from Alberta Children and Youth Services Enhancement Policy Manual in place in March, (this has been replaced by the manual marked as Exhibit 66 in October 2011). Exhibit 66 contains three distinct parts to the manual: intervention, placement resources and adoption. Ross explained some of the policies were changed pertaining to Exhibit 66, but many were not. Ross said that usually every six months to a year they try to update the manual. However and for example, if there are recommendations from a fatality inquiry, or investigative reviews from the child and youth advocate or similar events, there may be further updates. Ross explained that the policy in place regarding updates in 2010 was similar to that now in effect.

Exhibit 65 contains an overview of the Alberta foster care program, foster care program requirements, assessment of alternate childcare providers, application for a license or renewal of a foster home license, classification of homes, caseworker responsibilities for a child in foster care, expectations of foster parents and training requirements.

Exhibit 66 contains the current introduction to the enhancement policy manual which has policies and procedures that direct casework staff when delivering services. The policies provide direction and procedures for most common situations.

Exhibit 67 contains an excerpt of the intervention part of the said manual that relates to casework responsibilities; there was a corresponding chapter or excerpt in effect in 2010.

Exhibit 68 is the portion of the enhancement policy dealing with placement resources – reproduced is the table of contents plus some excerpts.

Exhibit 69 is a portion of the placement resources manual dealing with licensing of foster homes.

Exhibit 70 is a reproduction of a PowerPoint presentation entitled "Safe Babies Caregiver Education Program." This is an excerpt from mandatory training that family-based caregivers for children under the age of three are required to complete. In this context, family-based caregivers are foster parents and kinship caregivers. This module has been mandatory since the fall of 2014. This is module nine of 10 of the Safe Babies Caregiver Education Curriculum, which a caregiver is expected to take as soon as possible (ideally prior to receiving an infant). In addition to the modules for safe baby care, there is the expectation that foster parents will complete a 31-module program over four years, depending on the children they have in their care and their learning plan. Ross stated that with regard to the 10-module course for safe babies care, the foster care support worker is responsible to ensure that the foster parents know where to sign up, how that information gets back to them, what is a reasonable timeframe and what works for their schedules.

Ross stated that there is also an ability to prioritize particular modules and require them to be completed before a child is placed. The foster care caseworker or kinship care caseworker, as the case may be, would have the responsibility to ensure that this occurs in a timely fashion.

Ross explained that Pathways is a private organization facilitating the placement of children into foster care. There are other agencies doing similar work in the Edmonton area. The curriculum has been shared with all of the private agencies who are working with foster homes in Alberta. It is the foster care workers employed with the private agencies that are responsible for ensuring that caregivers take the required education within the applicable time frame(s).

Ross was questioned about certain provisions in Exhibit 68. Subsection 3.1.3 describes the application and approval requirements listing the detailed requirements for foster care approval. She said that these have not changed since the 2010 policy manual was in place. Ross explained that subsection 3.2.1, dealing with matching, indicates that upon identifying a potential match, there is an obligation to provide the foster parent with all information known about the child and the child's family that is relevant to the child's care. Ross commented that this sort of information would be medical, as well as a chronology of the child's time in care (as applicable), educational records and what precipitated the child coming into care, if known. Ross stated that it was the responsibility of the government caseworker working most directly with the child to provide this information to the foster parents. Ross felt this information would normally be shared with the private agency as well.

When asked about how much information is typically available about a child at the time the child is placed in foster care, Ross stated that there is no such thing as typical; it depends if the child is coming from another placement or if Children's Services has had any previous involvement with them. She said that Children's Services are often gathering information as they are placing and intervening with the biological family.

Ross testified that it expected that a new caregiver would make an appointment for a medical check-up of the child within two working days of the child coming into care. There are other requirements, depending upon the medical needs of the child in question. She stated that there was also the expectation that the child would be seen at least annually for a medical check unless directed more frequently by a physician. Information about the first medical appointment and any follow-up appointment would go to the caseworker, the foster parent and potentially the foster care support worker. The foster parent is tasked with making the arrangements and taking the child, but the caseworker needs to be informed of when that is, and what the instructions are. Sometimes the caseworker attends the appointment with the child.

Shylee's Involvement In Care Prior To Being Fostered By Christine and Kirby

Exhibit 6 details the chronology of Shylee being in care. She was born to Dallas (who has treaty status) at the Royal Alexandra Hospital in Edmonton, Alberta. Dallas was diagnosed with schizophrenia in 2001. Interaction with Dallas during the first few months after Shylee's birth resulted in various assessments and investigations. On September 15, 2008, an emergency apprehension was executed. From September 15 to December 19, 2008, Shylee was placed in a foster home. Dallas agreed to a three month Temporary Guardianship Order which was granted on September 23, 2008.

A medical appointment on September 22, 2008 found Shylee to be a little overweight; otherwise, she appeared healthy and well cared for.

On December 19, 2008, Shylee was returned to Dallas' care and an application was made for review of the Temporary Guardianship Order to terminate it and replace it with a Supervision Order consented to by Dallas. This Supervision Order remained in place from January 6, 2009 until April 5, 2009.

On April 3, 2009, Dallas signed a one-month Family Enhancement Agreement and a Family Enhancement Plan was completed with her caseworker.

On May 19, 2009, Shylee was apprehended under an emergency apprehension, due to challenges faced by Dallas at the time. Shylee appeared healthy and well cared for. Shylee was placed in a foster home from May 20 until July 31, 2009.

On June 3, 2009, a medical exam of Shylee noted no concerns.

On June 4, 2009, Dallas signed a Custody Agreement pertaining to Shylee. On July 28, 2009, Shylee returned to Dallas' care. Dallas signed a three month Family Enhancement Agreement and a Family Enhancement Plan was completed.

A further Family Enhancement Agreement was entered into and commenced on October 31, 2009.

On November 16, 2009, Shylee was apprehended under an emergency apprehension.

On November 18, 2009, an Initial Custody Order was granted.

On January 5, an Initial Custody Order was granted and the application for the Temporary Guardianship Order was adjourned.

On January 25, a caseworker took Shylee to her foster placement with Christine and Kirby. Shylee appeared healthy and happy.

Shylee Being Fostered by Christine and Kirby

- **Christine**

When Shylee arrived at the Residence, Christine, Kirby, Kaitlyn and G were residing there.

Christine provided weekly reports on the foster children to Pathways as well as email reports to Pollock. She said that these reports were to enable Pathways to "monitor how well the child is doing and anything that the child is going on or if we have any concerns." The last foster parent report regarding Shylee (dated February 24 prepared and submitted by Christine) referred to Shylee getting the flu on February 24. The report also described Shylee as having bruising on her back from sliding down the stairs and sitting in shopping carts, and that Dallas had complained about this bruising. Christine related that she had a doctor's appointment on February 17 to check Shylee because of an allegation of sexual abuse from Dallas. Christine stated that every time that Shylee would visit with Dallas, Dallas would allege that something had been done to Shylee.

Christine testified that she started sending emails to Pollock after every visit Shylee had with Dallas to advise Pollock what was going on with Shylee, because Dallas had said that "we had assaulted her, and that she had bruises all over her."

Christine confirmed that she submitted an Incident Report to Weir if Shylee got hurt or there was an incident involving other children. Christine referred to Exhibit 15 (page 575), being an Incident Report dated February 16 that Christine completed and faxed to Weir, about G hitting Shylee in the face, causing a bruise under her eye, on February 9. Christine testified that she usually sent emails reporting any injury to Shylee to determine if she had to complete an Incident Report about such injury.

On February 28, Christine dropped Shylee off at another foster home for 3 to 4 hours. When she picked up Shylee, Christine said that Shylee was crying, but stopped soon after they left the other foster home. That evening, Shylee sat and watched TV. She had not had a nap that day.

On February 28, Christine sent an email to Pollock describing that Shylee had a small scratch on her tummy, a small mark on her upper lip and a small, faint mark on her nose. That same day, Christine emailed an Incident Report to Weir regarding these same matters.

- **Kirby**

Kirby testified that the only matter involving Shylee that he was aware of prior to the Incident, was that she had a little mark around her eye from G hitting her with a toy.

- **Von Sprecken**

Von Sprecken stated that while Shylee was in care with Christine and Kirby, he would have had, at a minimum, monthly meetings with Weir. He said that Christine followed the correct procedure by reporting all little bumps and bruises that Shylee had. He stated that Christine and Kirby were not on Pathways' radar for breaking down, being overwhelmed or not being a good match. He said that while he was not aware of what details on Shylee, if any, were provided to Christine and Kirby, he felt that Children's Services would have been cautious and would have obtained as much information as possible before putting another child in their care. He added that they felt pretty confident matching Shylee to Christine and Kirby as foster parents.

Von Sprecken testified that foster parents are required to take a new foster child for a medical exam within 2 to 3 days after the child's placement, which is often at a Medicentre if not at the foster parents' regular doctor.

- **Meadahl**

Meadahl testified that the Placement Intake Screening is the written information that Pathways receives recording a child and which Pathways uses to determine whether or not there is a potential home to match. Her review of the Placement Intake Screening for Shylee showed no significant health information, which she said is not uncommon (depending on the type of apprehension that occurs).

Meadahl referred to Exhibit 16 (being Pathways placement confirmation memo for Shylee) showing what items were required and requested about Shylee from Children's Services.

Meadahl said that Christine was a really good emailer who kept very close contact with everybody, "so I think we all knew exactly when she was at the doctor or what was going on for the kids. So there was a really strong communication in that team."

Meadahl explained that a service team is comprised of the stakeholders or professionals that are involved; in this case, support worker Weir, caseworker Pollock as well as Christine and Kirby.

She explained that Pathways' policy in 2010 was that the support worker would be in the foster home once a month. She further stated that they would want a service team meeting to occur every three months and have bimonthly phone contact. Exhibit 17 contains a number of reports prepared pursuant to Pathways' policy, including the home study, which is a sanctioned form used throughout the province and supported by Pathways' policy. She said that the month end reports are agency driven and the annual evaluations are a condition of license. While stating that Pathways requires monthly reports, she also commented that the foster care support worker consults with the family and authors the report.

Meadahl referred to Exhibit 17, which contains a foster parent month end report for Shylee dated February 24th listing the caseworker as Pollock and the foster home as Christine and Kirby. Meadahl stated that if there was an incident that resulted in a critical incident report, such incident could be captured in the monthly report, but the expectation was that an incident report would be utilized. She said that these monthly reports were reviewed by Pathways upon receipt (that would take up to 30 days for a review by Pathways as they were sent out to the pertinent caseworker).

She confirmed that the Children's Services placement resource assessment team carried out the investigation of Christine and Kirby as a foster home later in 2010 after the Incident. Throughout this process, Meadahl said that Pathways was supportive of Christine and Kirby.

When asked, as a result of this investigation report being received were there any steps that Pathways took in relation to the findings, Meadahl said that arising from the outcome of the closure of Christine and Kirby as a foster home, there were no findings in Pathways' records to indicate that Pathways had any concerns or areas of deficit, except for one area whereby Pathways had failed to notify its contract consultant in writing; Pathways created a protocol for that. This was the only recommendation that was made. Meadahl stated that Pathways did a records review within 10 days of the Incident because they were incredibly concerned and did not really know what had happened. Any time there is a significant injury or death, Pathways conducts a records review; the entire child youth record as well as the caregiver record is reviewed. Meadahl confirmed that nothing significant came from Pathways' record review regarding Shylee.

Meadahl described that Exhibit 19 (Pathways and Family Services FC Outcomes Evaluation Report April 1, 2009 to March 31, 2010) relates to a requirement for Pathways to submit to its funder an annual report, including Pathways' outcomes, areas of growth and some templated questions. This report also includes the accreditation documentation of Pathways through a company called the "commission accreditation rehabilitation facilities". That accreditation expired in 2011 followed by reaccreditation thereafter.

When asked if there was anything that Pathways has concluded by way of a necessary or appropriate change to its policies, procedures or practices as a result of Shylee's death, Meadahl stated that Pathways did not find evidence to support making any changes.

- **Harder**

In 2010, Harder was employed by an organization called Changes. Changes was contracted by Children's Services to provide supervised visits between children in foster care and whoever the caseworker has set up visits with. Harder stated that she was a driver and supervisor in this regard.

Harder first met Shylee in December, 2009 when Shylee lived at a group home. Thereafter, Harder saw Shylee from January up to and including the day of the Incident.

Harder stated that Shylee was so happy, " a little ray of sunshine."

Harder was involved in transporting and supervising Shylee's visits with Dallas on Mondays and Wednesdays for planned three-hour periods. Initially, these visits occurred at Alberta Hospital where Dallas was located; thereafter, at the Children's Services office at Energy Square in Edmonton, Alberta.

- **Schrijvers**

Schrijvers testified that in 2010 she was a Level 2 foster parent with her husband, Michael.

On Sunday, February 28, Schrijvers babysat Shylee at Schrijvers' house after Christine had dropped Shylee off that day. There were six other young children at Schrijvers' house at that time, the visit of Shylee lasting 2 to 2½ hours

According to Schrijvers, Shylee seemed like a happy little girl who played well, was a little shy and very easygoing. During her time at Schrijvers' house, Shylee did not get upset or have any physical altercations with any of the other children. Schrijvers stated that she had no concerns with Shylee.

When Christine arrived to pick Shylee up, Schrijvers said that Shylee ran right to Christine.

Day of the Incident – March 1

- **Harder**

Harder picked Shylee up from the Residence at 7:45 AM to take her for a scheduled visit with Dallas at 9:00 AM at the Children's Services office in downtown Edmonton.

Harder said that Christine advised that Shylee had just woken up 5 to 10 minutes earlier and that she was extraordinarily tired. To Harder, Shylee seemed a little more tired than when she saw her the week before.

On the trip downtown (usually about 45 minutes to an hour) Shylee was singing and dancing (in her car seat) along with the music in Harder's car and playing with the velcro on her shoes like she normally did. She did not sleep on the way to the visit.

Harder and Shylee arrived for the visit about 8:45 AM and waited until 9:15 AM. During that time, Shylee played on the floor. She had a couple of temper tantrums (which Harder said were a little out of the ordinary for her). The first of these tantrums was because Harder took her keys away from Shylee. Shylee was sitting on the floor when this occurred and threw herself back as she was screaming and crying so that her entire body and head were on the floor. Harder picked Shylee up right away to console her. Harder said that Shylee did not seem to react verbally or physically to her head going back to the floor. Harder explained that the floor was covered with carpet.

Shylee also had a smaller temper tantrum when Harder tried to encourage her to clean up the paper that she had torn while playing on the floor as well as put away the toys she had been playing with. Shylee was sitting on the floor at the time and laid herself down (but did not throw herself back) and continued to scream. Compared to other days when Harder had asked Shylee to clean up, it was harder to get Shylee to cooperate. After 1 to 1½ minutes of lying down, Shylee calmed down and came to Harder.

As Dallas did not appear for the visit, Harder and Shylee left to drive back to the Residence. Harder said that Shylee fell asleep very quickly in the car for a "no visit" day, which was unusual. When they arrived at the Residence about 9:45 to 10:00 AM, Harder had to wake Shylee to take her out of the car.

- **Christine**

That morning Christine got Shylee up for her visit with Dallas. Shylee appeared fine and ate her breakfast.

Shylee arrived back at the Residence between 10:00 to 10:15 AM. She was a little upset, but calmed down eating some snacks and didn't do much else that day. Christine said that Shylee was not energetic and did not play with the other children.

Shylee ate a peanut butter sandwich for lunch in her high chair. Christine said that Shylee would take a few bites and then close her eyes. Christine would call her name, she would take a few more bites and she kept closing her eyes. Christine said that this was not normal for Shylee. When asked what she concluded about this behaviour, Christine said that she thought Shylee was just tired as she did not have her nap the day before. As well, Dallas did not appear for the visit so maybe Shylee was "off".

Christine put Shylee down for her usual nap at about 1:00 PM and Shylee slept. Christine got both Shylee and G up around 3:45 PM, changed their diapers and gave Shylee a bottle of juice. Christine said that she did not have any trouble waking Shylee.

Christine put Shylee on the linoleum floor, between the kitchen and the living room, facing the basement door, so Christine could see Shylee while Christine was in the kitchen making supper. At this time, Kaitlyn was on the couch and G elsewhere on the floor. Christine kept reminding Shylee to drink. Christine said that "she was just sitting there fidgeting with her feet or the sippy cup; she really wasn't doing anything else."

Christine was getting supper ready, having last looked at Shylee about a minute earlier, when, in her words, she heard "a bang and a little bit of a scream, and then when I looked over she had blood coming out of her mouth, like she had bit her lip or her tongue when she hit her head going back, and then that's when I realized she was -- I thought she was having a seizure." Christine said that Shylee was on her back, lying flat on the floor with her eyes "kind of rolling in the back of her head." Christine went over to Shylee and bent down to put her hand on Shylee's chest. Christine said that she looked at the stove clock which showed 4:15 PM, because she wanted to time it if Shylee was having a seizure. Christine said that Shylee had her arm lying behind her head and her body was twitching, "like a jerking motion".

Standing beside Shylee, Christine telephoned Kirby for a few seconds, who was outside the door, to come in to take Shylee to a doctor. Then Christine called 911 while she was down beside Shylee to see if Shylee was still breathing or if she had a heartbeat. Christine discovered a heartbeat and noted that Shylee seemed to be grasping for air. Christine rubbed Shylee's chest. During the 911 call, Christine told the operator that Shylee was banging her head on the floor from the seizure and that she had blood on her mouth. Christine said that she was moving her hand over the top of Shylee's chest to see if Shylee would wake up or take a breath. Shylee's back would arch like she was going to take a breath, that it seemed like she was taking air, but nothing came out.

Pursuant to the 911 operator's instructions:

1) Christine opened Shylee's mouth with her hands, but did not see anything, and

2) Christine then tried to assist Shylee to breathe, when she heard a gurgling sound and saw clear fluids in her mouth and throat and coming out of her nose, which looked like water.

After than telling the 911 operator that she could not feel Shylee's heartbeat, Christine was instructed to carry out CPR.

When EMS arrived on the scene, Christine continued doing CPR until a second EMS team got there. EMS removed Shylee from the Residence about 10 to 15 minutes later. Christine went with Shylee in the ambulance to the Sturgeon Hospital (St. Albert) where she and Kirby remained until Shylee was transferred to the Stollery Children's Hospital (Edmonton).

After going home to place G with other caregivers, Christine and Kirby went to the Stollery Children's Hospital where a social worker advised them to leave (for their safety) as Dallas was also there.

- **Kirby**

On March 1, after arriving home early from work around 3:45 to 4:00 PM, and while still in the driveway of the Residence, Kirby received a telephone call on his cell phone from Christine telling him to come into the Residence.

When he entered the Residence, Kirby saw Christine on the phone to 911 sitting beside Shylee, who was on her back on the floor. Kirby kept the other children away and held the phone to Christine's ear as she was doing CPR on Shylee. Kirby tried once rubbing Shylee's chest to see if she would wake up, but received no response.

Kirby did not see any injuries or marks on Shylee that day.

Medical Intervention

The EMS form completed on March 1 [Exhibit 1], indicates that at the time of EMS arrival, Shylee was blue in the face and lifeless and further, that she was unconscious and unresponsive with no evidence of trauma. EMS was at the Residence from 4:43 PM until 5:07 PM and arrived at the Sturgeon Hospital at 5:17 PM.

Exhibit 2 is a copy of the Sturgeon Hospital records and Exhibit 3 is a copy of the University of Alberta (Stollery Children's Hospital) hospital records. These records detail the respective medical interventions carried out with unfortunately no effect.

Autopsy Report

The Autopsy Report forming part of Exhibit 4 was signed on June 9 by Sauvageau.

The narrative summary of findings and conclusions related to death stated as follows:

"This 21 month old female was a foster child. The foster family noticed the child did not seem well and took her to the Sturgeon General Hospital on March 1, 2010. The child was then forwarded onto the University of Alberta Hospital where she was found to have retinal hemorrhages and cerebral edema. She was pronounced brain-dead on the March 3, 2010. No recent traumatic event was reported by the foster family. At autopsy, an acute subdural hematoma is found along with an acute subarachnoid hemorrhage, massive brain edema, bilateral hemorrhage of the optic nerve sheaths and multiple bilateral retinal hemorrhages. The cause of death is non-accidental traumatic head injury."

NOTE: Although both the Autopsy Report and the Certificate of Medical Examiner signed by Sauvageau (Exhibit 4) refer to Shylee being pronounced brain dead on "the March 3, 2010," the date of death in both documents is listed as March 2, 2010.

By way of further explanation, reference is made to Exhibit 43 where, as part of the agreed facts in Christine's trial, it was stated:

"On March 2nd, 2010, at 4:31 PM, a first neurologic determination of brain death examination was conducted with respect to Shylee. On March 3rd, 2010, following a second neurologic determination of brain death examination, Shylee was removed from respiratory and circulatory support. Shylee's time of death was pronounced as of March 2nd, 2010, following the first brain death determination."

Dr. Ophoven's Opinion of Shylee's Death

Exhibit 63 is an excerpt of the transcript of the criminal trial of Christine relating to the testimony of Ophoven. The following hypothetical situation was presented to Ophoven:

"So please assume that you're dealing with the case with an apparently previous healthy child, 20 months old, for -- who had -- was previously healthy, but for an episode of vomiting a few days prior to the event, height being 83 cm or, in American terms, I believe that's about 2½ feet and weighing 15 kg or 33 pounds. The child didn't seem as active the night before the event. The child was also noted to be less energetic than usual the following morning. The day of the event, the child leaves its home at approximately 7:45 for about 2½ hours and returns at 10:15. The child has a runny nose.

At lunch, the child appeared to be falling asleep. About 4:30 PM, the caregiver gives the child her sippy cup. The child falls back from either a standing or seated position and cries. The child appears to be seizing. The caregiver calls 911 shortly thereafter. The child appears unconscious. The child is having difficulty breathing, but has a pulse. The caregiver can hear the child gurgling, and there is fluid in her mouth, throat. Liquids are coming out of the child's nose. While waiting for emergency responders to arrive, the caregiver can no longer feel a pulse. CPR is initiated by the caregiver with guidance from the 911 operator. The child was having difficulty breathing from 4:33 PM onward. The child was without a pulse at least from the time EMS responded at 1645 or 4:45 PM and 5:16 PM. Within 1.5 minutes of arrival, the attending paramedic had unblocked vomitus from the child's airway. Please assume that you have the hospital records and CT scans as they are before the Court which record the injuries and progression of injury plus the x-rays taken both at the Sturgeon and Stollery Hospitals as well as the autopsy report and autopsy photos plus your own examination of the tissue slides. There is no recent history of traumatic event prior to the child's collapse. What is your opinion to the initial question posed? That is, what caused the death of Shylee Kasokeo in your professional opinion?

Shylee died from complications of lack of oxygen to the brain following cardiac arrest associated with seizures and blocked airway with vomitus and prolonged cardiac arrest."

Case File Review of Shylee's Death

Adeagbo, a forensic pathologist, completed a case file review of cause of death in this matter. Exhibit 64 contains his case file review report letter dated October 21, 2017 as well as his resume.

Adeagbo provided testimony to the Inquiry in support of his case file review after being qualified as an expert in the area of forensic pathology and entitled to give opinion evidence in that area. He stated that he was a certified Independent Medical Examiner currently employed with the Office of the Chief Medical Examiner in Calgary, Alberta, and has been since January, 2012.

At the beginning of Adeagbo's testimony, he was asked if he had ever worked with Ophoven, who also provided a medical opinion to a court in this case (as above). Adeagbo acknowledged that he was aware of who she was, but had not had contact with her in any way and no relationship with her apart from the fact that she is a colleague of his.

In his case file review, Adeagbo described the documents and items that he received and reviewed in order to provide his opinion. In addition, Adeagbo received transcripts of the 911 calls made by Christine.

The case file review lists background information as well as a summary of the medical records extract, which was confirmed as a summary of the pertinent information Adeagbo obtained from the material he received.

The reference in the case file review to imaging studies means a summary of observations by others.

Adeagbo said that his review of histologic slides resulted from his independent examination of the said slides and his findings accordingly.

Adeagbo stated that he did not have the autopsy photographs available, which did create a handicap for him. He said that a picture adds documentation of the findings, especially the gross findings. However, such deficit did not prohibit him from coming to an opinion based on the material available to him.

Specific reference was made to item 7 of his opinions where he stated: "At Stollery Children's Hospital, on March 2, 2010, she was assessed to have facial bruises, bilateral retinal hemorrhages, cerebral and possible cerebellar edema." Adeagbo confirmed this opinion as per the clinical information available to him. He further explained that Shylee was admitted on March 1, but it was on March 2 that the facial bruises were reported for the first time. This shows that there is a possibility that the bruises existed, but were not seen until March 2, or were not there, but actually got there for the first time on March 2.

He stated that the bilateral retinal hemorrhage was reported first on March 2. That suggests a problem with the temporary relationship of that finding to a particular time of injury, because the hemorrhage was not reported on the very first time she was admitted at the hospital; there were events, such as medical intervention, that could explain the retinal hemorrhage. The medical intervention was performed on Shylee the day before. Therefore, the significance of the these findings requires careful deliberation, and the pathologist must have an open mind and look at all the context before determining the significance of these findings.

The other finding he referenced was cerebral and possible cerebellar edema. Resuscitation, prolonged period of medical intervention and a period of inadequate oxygenation all could lead to this finding (from the emergency medical record, the intervention at the Sturgeon ER could lead to these findings).

Further, Adeagbo confirmed that there are potentially multiple causes for the cerebral and possible cerebellar edema (meaning swelling due to fluid retention).

He drew specific attention to opinion 13, being the lung findings. Adeagbo described diffuse alveoli damage evidence of aspiration of foreign substance; in other words, that there were reactive changes in the lungs. He went on to describe that reactive changes in the lungs are due to several possible factors; infection, lack of respiration, respiratory effort that leads to destruction in the integrity of the lung tissue and aspiration of material not inherent to the lungs [such as food materials]. All these could lead to diffuse change in the lungs and be described as diffuse alveoli damage. He found materials in Shylee's lungs he described as striated [coagulated], which was most likely aspirated meat.

He explained that it is possible that during cardiopulmonary resuscitation, stomach contents could be expelled from the stomach through the esophagus with the potential that such stomach contents would be aspirated into the airway down to the lungs. Cardiopulmonary resuscitation itself, by just the sheer impact on the lungs, could develop some reactive changes. However, this was not reported in the Autopsy Report.

In his opinion 15, Adeagbo agreed with the Autopsy Report that there were changes in the brain that suggest that the brain did not have sufficient oxygenation and blood supply. However, from the slides that he reviewed, Adeagbo did not note any acute subdural hematoma, diffuse (wide spread) acute subarachnoid hemorrhage or massive spread edema.

An issue for him was that he did not receive a description as to what tissue or organ a particular slide was taken from. Further, he stated that if a subdural hematoma and arachnoid hemorrhage was found at the autopsy there would be an expectation that the CT scan of the head carried out at the time could show that it was there when that CT scan was done. However, the CT scan on the head performed on March 1, [as stated in his case review file] states "note definite inter-cranial hemorrhage is identified." He went on to explain that it is possible to have this finding at the autopsy because there have been cases that, after prolonged resuscitation and life-sustaining measures, people could develop all these findings, subdural and subarachnoid. In his words, "so technically, we have to be very careful and very observant when we do this case, because a lot of things that can present and can be easily misinterpreted."

Further, he stated that he did not see an acute subarachnoid hemorrhage in the slides that he examined, despite reference in the Autopsy Report to a finding of diffuse acute subarachnoid hemorrhage.

Adeagbo explained that his observance of the presence of eosinophilic neurons in the brain is consistent with lack of oxygen or hypoxia. This would suggest that the brain does not have enough oxygen and is being injured as a result.

Adeagbo further explained that the observance in the Autopsy Report of an acute subdural hematoma as well as a diffuse acute subarachnoid hemorrhage (neither of which he found) could both be postmortem artifact (caused when the brain was being removed).

As to the hemorrhages in the eyes referred to in the Autopsy Report, Adeagbo felt that such hemorrhages were all acute, fresh. He said that there were no additional studies done at the initial autopsy to show that such hemorrhages were new or old. Adeagbo said that if you cannot confirm the age of such hemorrhages, the possibility that they occurred due to resuscitation cannot be ruled out. It could have happened due to the process of hypoxic changes because Shylee was not getting oxygen; her brain was swelling (because this also has been associated with swollen brain). Adeagbo felt that where you have one, or two alternative theories of how something can happen, the importance of that finding has to be carefully looked at and reviewed before you conclude on it.

Further, he stated, “but at the end of the day, we do not make a -- a determination based on hemorrhage -- based on retinal hemorrhage. It is based on the totality of the findings.” He went on to describe that such findings are not pathognomonic of any mode of injury, which is true, or aetiology. This means that such findings are not the result of a particular disease or cause. He said there is literature filled with retinal hemorrhage on different levels associated with cardiopulmonary resuscitation and even obstructive airway.

As well, Adeagbo noted that bloodshot eyes just from sneezing are possible. Adeagbo felt that one had to be careful in interpreting findings by ruling out possibilities, which was not done at the time.

Adeagbo explained that if he had carried out the original autopsy on Shylee, he would have instructed a biological culture report [which was not done in this case] and which may have shown something further.

In response to a question about his conclusion respecting the manner and cause of Shylee’s death based on all the materials that he has reviewed, including all the medical reports that are available in relation to Shylee as well as the testimony of a number of medical professionals, Adeagbo repeated what he concluded in his case review file; that the cause of death is undetermined. He went on to say that there were lots of possibilities in this case which were not ruled out; natural disease, aspiration, and infliction of some kind of trauma. As he stated, “So at the end of the day, I think this autopsy, as it stands, and the finding there cannot provide a cause of death, nor can it provide a definite mode of death.”

Adeagbo went on to describe what is commonly referred to as “shaken baby syndrome.” He stated that a few doctors still believe that this syndrome is comprised of the triad of subdural hemorrhage, subarachnoid hemorrhage and retinal hemorrhage as well as perhaps cerebral edema. He further explained that all the findings that are associated with these indicators of shaken baby syndrome are controversial to start with and they are not a unique pathologic finding. As such, there are very few doctors that actually consider that as an entity.

Further, if one is actually thinking of shaken baby syndrome, one may have to do further reviews, which were not done in this case. He went on to describe that, regarding the force needed to actually whiplash back and forth the baby’s head to be significant enough to cause some damage on the neck, you need to look at the neck and check for some injury of the cervical spinal cord, which was not done in this case. Further, when one looks at all of the findings that could support shaken baby syndrome, he could not confirm them in this case.

Reference was made to the Autopsy Report which stated “the neck, thorax and abdomen are unremarkable.” Adeagbo stated that the other thing he was looking for was “reference to internal examination of the neck”, which was not documented. He stated that maybe the neck was examined and there was nothing significant noted, but such was not stated in the Autopsy Report. Further, he explained that the findings of the aforesaid triad of indicators supporting shaken baby syndrome would probably have been observed right from the very first day of Shylee’s admission.

Submissions

Duckett confirmed that her standing instructions were to take no position respecting any recommendations that this Court may make However, I concur with the following comments made by Duckett, namely:

- It would appear from all of the medical information contained in the Exhibits that there was no pre-existing health concern respecting Shylee.

- There is evidence of Dallas's dissatisfaction with Shylee's caseworker as well as sporadic and somewhat irregular contact by Dallas with the caseworker and Shylee.

Conclusion

Revisiting the issues expressed in the initial correspondence from Duckett to this Court dated March 24, 2017, namely:

1. *Can the cause and manner of Shylee's death be determined with any greater certainty?*

As to the cause and manner of Shylee's death, there are, before this Inquiry, contradictory opinions. Sauvageau expressed in both the Certificate of Medical Examiner and Autopsy Report [Exhibit 4] that the immediate cause of death was "non-accidental traumatic head injury." Ophoven opined that Shylee died from complications of lack of oxygen to the brain following cardiac arrest associated with seizures and blocked airway and prolonged cardiac arrest. Adeagbo's opinion, as to both the cause and manner of Shylee's death, is that such cause and manner is undeterminable. He testified there are several possibilities that cut across different matters of death, including natural and accidental. The possibility of homicide was thoroughly considered, but he did not see sufficient postmortem evidence to support or rule out that possibility.

Due to the existence of other possibilities as to the cause and manner of Shylee's death not being ruled out in the autopsy process, I find that both the cause and manner of Shylee's death to be undeterminable.

2. *Should different or additional measures have been taken in placing Shylee, in supervising or supporting the foster parents or in obtaining information after the placement?*

Nothing in either the testimony or the Exhibits before this Inquiry gave rise to concerns on behalf of Children's Services or Pathways regarding the placement of Shylee with Christine and Kirby, the support given to Christine and Kirby for Shylee or a lack of information from Christine and Kirby on Shylee.

Recommendations for the prevention of similar deaths:

This Inquiry has no recommendations for the prevention of similar deaths.

DATED June 1 ,2018

at St. Albert , Alberta.

"B. R. Garriock"

Bruce R. Garriock
A Judge of the Provincial Court of Alberta

Public Fatality Inquiry – Shylee Kasokeo
Table of Contents

12	Kokum's House documents – 16 p.	Dec 2009 – Jan 2010	
13	Supervised Visit Reports - 14 p.	Dec 15, 2009 – March 1, 2010	
14	Incident Report Duty Report Placement Resource Screening Form- 7 p. Email relating to occurrence	March 2, 2010 March 1, 2010 March 2, 2010 March 3, 2010	Christine Laverdiere Cheryl Stuart Matthew Polack Liz Hedegaard
15	Volume of documents containing emails, contact notes and incident reports	Dec 2009 – Feb 2010	
16	Pathways Agency – Shylee placement information – 5 p.	Jan 2010	
17	Laverdiere Home Information Home Assessment – 15 p. Licensing documents – 10 p. Foster Home Yearly Eval. –5p. Foster Home Yearly Eval – 5p. Foster Par. Mo. End Rpt. – 5p. Foster Par. Mo. End Rpt – 5p. Foster Home Yearly Eval.- 7p.	April 12, 2008 Various October 7, 2008 March 24, 2009 January 27, 2010 February 24, 2010 March 11, 2010	
18	Intervention Assessment documents	August 2010	
19	Pathways Agency information: FC Outcomes Eval. Rpt and attachments – 48 pages Accreditation Documents	Apr 1/09 – Mar 31/10 2008	

RCMP Documents

20	Photograph of Shylee Kasokeo	unknown	unknown
21	Transcript of Parkland County 911 call 1 Mar 2010 – 2 pages	1 Mar 2010	
22	Transcript - Strathcona County 911 call 1 Mar 2010–20 pages	1 Mar 2010	

23	Recording of 911 calls	1 Mar 2010	
24	Map of Laverdiere neighbourhood	undated	
25	Photos of main floor inside Laverdiere home	undated	
26	Transcript of statement of K. Laverdiere – 15 pages	2 Mar 2010 at 19:05 hrs.	Kirby Laverdiere to Cpl. Zazulak
27	Transcript of statement of C. Laverdiere– 31 pages	2 Mar 2010 at 19:37 hrs.	Christine Laverdiere to Cpl. Zazulak
28	Transcript of statement of C. Laverdiere – 18 pages	3 Mar 2010 at 6:44 p.m.	Christine Laverdiere to Cst. Mulroy
29	Transcript of statement of C. Laverdiere – 128 pages	23 Mar 10 at 13:49 hrs.	Christine Laverdiere to Sgt. Imschoot
30	Transcript of statement of C. Laverdiere – 131 pages	28 May 2010 at 13:08 hrs.	Christine Laverdiere to Sgt. Imschoot
31	Transcript of statement of J. Coppens – 15 pages	3 Mar 2010 at 6:46 p.m.	Jacques Coppens to Cpl. Hanson
32	Transcript of statement of R. Bunten – 20 pages	3 Mar 2010 at 15:46 hrs.	Richard Bunten to Cst. Scott and Cpl. Hanson
33	Transcript of statement of Dr. C. Bauer – 11 pages	8 Mar 2010 at 12:10 p.m.	Dr. Christopher Bauer to Cpl. Zazulak and Cst. Mulroy
34	Transcript of statement of T. Schrijvers – 15 pages	3 Mar 2010 at 4:12 p.m.	Tammy Schrijvers to Cst. Mulroy
35	Transcript of statement of M. Schrijvers – 26 pages	3 Mar 2010 at 21:05 hours	Michael Schrijvers to Cst. Bignell and Cst. Blackmore
36	Transcript of statement of K. Harder – 33 pages	3 Mar 2010 at 19:15 hrs.	Kelly Harder to Cst. Scott
37	Transcript of statement of K. Harder – 36 pages	16 Mar 2010	Kelly Harder to Sgt. Imschoot and Cpl. Knopp

38	Transcript of re-enactment by K. Harder – 42 pages	16 Mar 2010 at 10:45 hrs.	Kelly Harder with Sgt. Imschoot and Cpl. Knopp
39	Transcript of statement of D. Kasokeo – 18 pages	4 Mar 2010 at 13:17 hrs.	Dallas Kasokeo to Cst. Bignell and Cst. Blackmore
40	Supervised visit reports	Various dates: 28 May 2009 – 1 Mar 2010	various

Court Documents

41	*R. v. Laverdiere*, 2014 ABQB 161	Reasons for Judgment	The Hon. Madam Justice M.T. Moreau
42	*R. v. Laverdiere*, 2014 ABQB 68	*Voir Dire* reasons for decision	The Hon. Madam Justice M.T. Moreau
43	Trial Excerpt Pages i - 7	13 Jan 2014	Table of Contents Agreed Stmt. Of Facts
44	Trial Excerpt Pages 190 - 211	16 Jan 2014	Kirby Laverdiere testimony
45	Trial Excerpt Pages 223-266	17 Jan 2014	Jacques Coppens testimony
46	Trial Excerpt Pages 269-282	17 Jan 2014	Dwayne Von Sprecken testimony
47	Trial Excerpt Pages 297-320	20 Jan 2014	Dr. Jeffrey Pugh testimony
48	Trial Excerpt Pages 323-346	20 Jan 2014	Dr. Harold Climenhaga testimony
49	Trial Excerpt Pages 361-375	21 Jan 2014	Dr. Michelle Noga testimony
50	Trial Excerpt Pages 379-398	21 Jan 2014	Dr. Christopher Westover testimony

51	Trial Excerpt Pages 405-420	21 Jan 2014	Dr. Richard Bunten testimony
52	Trial Excerpt Pages 420-456	21 Jan 2014	Dr. Alf Conradi testimony
53	Trial Excerpt Pages 463-496	22 Jan 2014	Dr. Lionel Dibden testimony
54	Trial Excerpt Pages 503-594	27 Jan 2014	Dr. Anny Sauvageau testimony
55	Trial Excerpt Pages 602-612	3 Feb 2014	Matthew Polack testimony
56	Trial Excerpt Pages 613-621	3 Feb 2014	Valorie Weir testimony
57	Trial Excerpt Pages 629-661	4 Feb 2014	Tammy Schrijvers testimony
58	Trial Exhibit 19	4 Feb 2014	Drawing by Ms. Schrijvers
59	Trial Excerpt Pages 752-784	18 Feb 2014	Kelly Harder testimony
60	Trial Excerpt Pages 790-803	18 Feb 2014	Melody Kaiswatum testimony
61	Trial Exhibit 23	15 Mar 2010	Interview transcript Melody Kaiswatum
62	Trial Exhibit 24	15 Mar 2010	Drawing by Melody Kaiswatum
63	Trial Excerpt Pages 807-865; 892-934	20, 21 Feb 2014	Dr. Janice Ophoven testimony

Medical Examiner's Report

64	ME Report	2017	Dr. Bamidele Adeagbo

Public Fatality Inquiry – Shylee Kasokeo
Table of Contents
Volume III