ALBERTA

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

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Law Courts Building

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

on the 22nd day of June, 2015 (year), (and by adjournment

on the 25th day of June, 2015 (year)),

before The Honourable S. M. Bilodeau, a Provincial Court Judge,

into the death of Delonna Victoria Sullivan (Name in Full) 4 mos (Age)

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

Date and Time of Death: April 11, 2011 at 4:17 p.m.

Place: Stollery Children's Hospital, Edmonton

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)).

Sudden Unexplained Death in Infancy

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)).

Undeterminable

Circumstances under which Death occurred:

This is a report to the Minister of Justice and Solicitor General in relation to an inquiry conducted pursuant to the provisions of the *Fatalities Inquiries Act* R.S.A. 2000, F-9 into the death of Delonna Sullivan on April 11, 2011. The deceased was a 4 month old baby who was apprehended by Children and Youth Services ("CYS") and died while in the care of a foster parent.

The evidence at the Inquiry was presented by Inquiry Counsel, Lara Levesque. Kate Bridgett and Andrew Pearcey represented the CYS Director. The Royal Canadian Mounted Police was granted standing to appear at the Inquiry and they were represented by David Stam. The next of kin were represented by Larry McConnell, Q.C..

The Inquiry spanned four days during which much evidence was heard concerning the circumstances of and justification for the apprehension of Delonna from her mother. Given the parameters of this Inquiry's mandate, it is neither necessary nor appropriate to make any conclusions or comment on the emergency apprehension. Suffice it to say that the child was apprehended and placed into the care of a foster parent later that same day: April 5, 2011. That action had no bearing whatsoever on the manner or cause of death.

The foster parent was approved by CYS and had a positive history with them as a foster parent over the preceding ten years. She had successfully completed all of the training required of foster parents at that juncture including annual updates. The training included education on the subject of "safe sleep". She had a particular interest in infants and had previously provided care to at least six different infants.

The sleeping arrangements for the infant were in accordance with safety standards and approved of by CYS. The "Pack 'N Play" is described as a playard, portable crib, and bassinet. The bassinet portion sits on top of the main playpen and is the place where the baby would sleep. It is designed for that purpose for infants up to 6.6 kg (15 pounds) in weight. At the time, Delonna was approximately 6 kg (13 pounds). The bassinet and playpen were described in the evidence as being appropriate for use as a temporary sleeping place for children. This references the manufacturer's stipulation that children should not be left in it to sleep once they attain the indicated weight, or when they start rolling or pushing up on their hands and knees. That generally happens well before the child's first year, therefore, a crib is the preferred longer-term sleeping solution.

The evidence was contradictory on the issue of whether or not the foster parent had a baby monitor at the time Delonna was with her. In her testimony, the foster parent testified that she did have a baby monitor and that she used it on April 11. However, after the child's death, the subsequent CYS investigation recorded the foster parent as stating that she did not have a baby monitor at that time and would be obtaining one. This detail is unresolved.

On the morning of April 11, 2011 the foster parent was getting her own two children ready for school. Delonna had not had a particularly good sleep that previous night; she was not yet in a sleeping pattern and had been up for much of the night. At 4:00 or 5:00 a.m. the child fell asleep but was awake by 8:00 o'clock. By 10:00 a.m. she was ready for another sleep and the foster mother put her to bed. She fell asleep in her bassinet which was in the foster parent's own bedroom. The door was closed to prevent the pets from coming in and waking the child.

The foster parent did not go into the room to check on Delonna but testified that she could hear her on the monitor. The child continued to sleep into the afternoon. The foster parent has a clear recollection of hearing the baby making sounds at approximately 2:00 in the

afternoon. The foster parent was speaking to a friend on the telephone when she heard the baby stir. She told her friend that she would have to go because the baby was waking up. When the foster parent hung up the phone, the baby was quiet again and the foster parent thought that she had dozed off. Rather than being concerned, the foster parent was pleased that Delonna was getting a good sleep. At 3:30 the foster parent went to get Delonna so that the baby would be fed prior to her own children returning from school. She went into the bedroom and saw the baby laying in her bassinet, on her back with her face uncovered. The child was not breathing. The foster parent took the baby into the kitchen, called 911 for emergency assistance, and began CPR in accordance with her training. First responders arrived reasonably quickly and found the infant to be completely non-responsive. Delonna was brought to hospital where she was pronounced dead.

The autopsy was conducted by Dr. Graeme Dowling, one of the foremost respected medical examiners. Formerly the Chief Medical Examiner, Dr. Dowling is now retired and so his file was reviewed by the present Deputy Chief Medical Examiner, Dr. Elizabeth Brooks-Lim. Dr. Brooks-Lim's credentials are exceedingly impressive and the Court was able to accept her opinions and conclusions unreservedly. She concurred with those of Dr. Dowling. The doctor described the deceased as having been well fed and well grown for her age. There were the slightest scratches noted on the back of the baby's scalp and ear which the doctor said were consistent with the scratches one sees from a child's own fingernails. A thorough physical examination was conducted and there were no marks to cause concern. An abrasion on the baby's chest was consistent with CPR efforts that were conducted by the foster parent and first responders. The external examination showed nothing of concern. The doctors also x-rayed the deceased to look for fractures or injuries; none were found. There was no trauma or indication of natural disease. There was no evidence of lung disease or pneumonia. A bacterial presence in the deceased's lungs was explained by the doctor as being a common post-mortem finding which is irrelevant to the cause of death. An examination of tissue samples showed no evidence of infection or natural disease processes. The doctors performed a blood test to look for metabolic diseases. No such evidence was found. The toxicology report showed cold medicine in quantities consistent with what was described by the foster parent in her testimony.

On this point, the foster parent had noted that Delonna arrived with a slight cold which she treated by way of over-the-counter Children's Tylenol cold medicine. She testified that she gave the dose indicated on the medicine's packaging. Witnesses from CYS confirmed that she was permitted to give normal over-the-counter medicines to foster children. The foster parent also testified that the child had a bout of diarrhea one day which she treated with gripe water. Again, this was permissible as far as CYS was concerned.

The autopsy included an analysis of Delonna's electrolytes and sodium levels. The results were consistent with the child having had diarrhea. The doctor was clear in her testimony that the levels were not such as to indicate that the dehydration was in any way linked to the child's death.

In conclusion, there was nothing found which would evidence that this baby was unwell at the time of her death. There was no evidence of smothering. There was nothing in the autopsy which would explain this baby's death. The ultimate conclusion of both doctors is that the cause of Delonna's death is unexplained.

The previous terminology given for this conclusion was "Sudden Infant Death Syndrome" (or "SIDS"). That terminology was changed within the medical community to "Sudden Unexplained Death in Infancy". At the present time, the preferred reference to this conclusion is simply "unexplained" as it is considered to be somewhat misleading to attach a label to this phenomenon. When a child dies in this manner, there are no symptoms. There are no

warning signs. Dr. Brooks-Lim provided evidence as to the frequency of this tragic occurrence. She noted:

> As of January 2006 the Office of the Chief Medical Examiner has investigated 1048 cases of deaths of children in Alberta where the child was under 1 year of age, excluding stillbirths and deaths within hours of birth. Of these 1048 investigations:
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> - 114 deaths were determined to be due to "Sudden Infant Death Syndrome" or "Sudden Unexplained Death in Infancy" or an equivalent phraseology on the death certificate;
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> - 52 deaths were found to be "Undetermined" as a cause of death. These cases involved children who were found unresponsive in a crib/bed environment where the child had not been co-sleeping with another child or adult.
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> This would amount to an overall total of 166 deaths over 9 years (an average of 18 cases a year) in Alberta.[1]

Dr. Dowling's autopsy report indicates that "the infant's sleep environment was not completely safe in that she had been placed to sleep on an infant carrier, there was a loose fitting bedsheet beneath her, and the single cover sheet was also loose." Testimony from the foster parent concurred that there was a fitted sheet which was an optional accessory offered by the manufacturer and this was on the bassinet. Furthermore, Delonna's mother had provided a small blanket (described as being marginally larger than a facecloth) for Delonna to sleep with. These are the items referenced by Dr. Dowling. Dr. Brooks-Lim clarified what was meant by "not completely safe". She stated that the scientific medical community cannot determine why these otherwise perfectly healthy babies die in their sleep. Therefore they have looked at case findings and have come up with recommendations to minimize the risk to children (also described as "safe sleep"). The doctor said that the sleeping environment a scientist would like to see would involve the baby sleeping alone on its back with no blankets on a mattress on the floor. There would be nothing at risk to interfere with breathing and if the child rolled off the mattress it would not have far to fall. There would be no bars or railings to pose any threat to the child. This would be the ideal situation. It follows that any deviation from that ideal is considered to be "less safe". This explanation distinguishes "not completely safe" from simply saying "unsafe". It is my conclusion that the deceased's sleep environment was, in fact, safe and that it met the requirements set at that time by CYS.

Policies put in place for foster parents stipulate "safe sleep" measures which are expected of them in regards to children in their care. Since the date of Delonna's death, CYS has revised those policies (for reasons unrelated to this case) and they more closely detail the safety recommendations outlined by Dr. Brooks-Lim. In addition, foster parents' training includes a considerable amount of material relating to appropriate sleeping arrangements for children. The policies and educational/training materials reflect the currently known "best practices" for safe sleeping environments. It is also evident that CYS regularly updates these materials and practices as new and better information is learned.

CYS policies require that foster parents book a doctor's appointment for the child within 2 working days of the child entering the Director's care. The evidence in this case indicates

[1] For late 2014 and 2015 there are still outstanding uncompleted cases which are not included in these statistics. Further, the Office of the Chief Medical Examiner would not investigate deaths of children under the age of 1 year that are due to natural causes where the attending physician is able to write a death certificate without the M.E.'s involvement. These would be instances such as a complex natural disease process that leads to the expected death of an unfortunate child.

that the foster parent had planned on making the doctor's appointment on April 12, with the expectation that the doctor would see her that same day. That is 5 working days after the child was placed in her care as opposed to the 2 days which is stated in the policy. The reason for this delay was explained by the foster parent in her testimony. Ultimately, it did not play any role in the death. Because the autopsy showed no signs of ill-health or disease, there is no reason to believe that a medical examination in the days before the death would have disclosed anything of concern. The minor deviation from written policy was simply not a factor.

On the matter of supervision, the foster parent was in the residence while the child was sleeping. The foster parent was sober and alert at all times. Her sworn testimony was that she could hear the child throughout the course of the day and, in particular, at around two o'clock in the afternoon. She stated that on the witness stand and she stated that in her earlier interview with the CYS investigators. Whether or not she had a baby monitor, the child was not unsupervised while she slept. Therefore, this plays no role in the cause or manner of death.

In conclusion, this otherwise healthy baby died for an unexplained reason as have other babies all over the world for many, many years. It is a medical mystery why this happens. She happened to be in the good care of a foster parent at the time this occurred.

Recommendations for the prevention of similar deaths:

There is nothing in the evidence to substantiate a recommendation which could plausibly prevent, or even further reduce the risk of, Sudden Unexplained Death in Infants. The suggestions from the scientific and medical communities aimed at reducing the risk of this tragic occurrence are already in place in the Children & Youth Services' "Safe Sleep" policies, procedures and training.

Accordingly, this Court makes no recommendations for the prevention of similar deaths.

DATED July 10, 2015,

at Edmonton, Alberta.

Original signed by

The Honourable S. M. Bilodeau
A Judge of the Provincial Court of Alberta