Ontario

Ministry of the Solicitor General | Office of the Chief Coroner

Ministère du Solliciteur général | Bureau du coroner en chef

Verdict of Coroner's Jury / Verdict du jury du coroner

(95) 14822

The jury serving on the inquest into the death of: / Jurés dûment assermentés à l'enquête sur le décès de:

Surname / Nom de famille	Given names / Prénom
FREE PARKIN	Kenneth & Mitchell

aged / âgé(e) de 2½ months held at / qui a été menée à Court house 50 Main St E HAMILTON

on the / le 20/21/22nd day(s) of / (du/au) November 19 95

by / par Dr W LUCAS Coroner for Ontario, / coroner pour l'Ontario,

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

1. Name of deceased / Nom du (de la) défunt(e): FREE PARKIN Kenneth & Mitchell
2. Date and time of death / Date et heure du décès: January 12, 1995
3. Place of death / Lieu du décès: Hamilton, Ontario
4. Cause of death / Cause du décès: Sudden unexplained death in an infant
5. By what means / Circonstances entourant le décès: natural causes

This verdict was received by me this / Ce verdict a été reçu par moi le 22 day of November 19 95

J.J. Lucas

Signature of Coroner / Signature du coroner

Distribution: Original - Regional Coroner for forwarding to Chief Coroner / L'original - coroner de la région pour transmission au coroner en chef
Copy - Crown Attorney / Copie - Procureur de la Couronne

CC 011(Rev 06/89)

B.M.B.P. DEC - 8 1995

B.M.R.P

Children are our very most important resource. We, therefore XXX
We wish to make the following recommendations: / Nous souhaitons faire les recommandations suivantes:
to the Ontario Association of Childrens' Aid Society to implement a standard risk assessment tool to be used by all CAS in Ontario.

Purpose:

a. gives the immediate risk (ie. low, moderate, high)

b. helps eliminate gaps in assessment during transfer to different societies in Ontario.

c. to ensure quick and appropriate action be taken.

2. In cases of multiple births, separate approved cribs must be used.

3. Training role within the CAS to engender further awareness of the SIDS issue. (supine position in sleeping, overheating, maternal smoking and second hand smoke).

PUBLIC AWARENESS RECOMMENDATIONS

1. Medical education of SIDS through health care professionals. Public Health Units, family physicians, pediatricians and hospitals are to target new young mothers on recommended sleeping position, how much, how little clothing and smoking.

2. Implementation of Ontario Government multi-media awareness to target the general public on SIDS.

3. Formal education

Sids awareness should be included with sex education in senior grade schools. High school parenting classes should also highlight SIDS awareness. Baby sitter courses, and care giver centres should also include SIDS in their training curriculum.

Office of the Chief Coroner of Ontario to submit a progress report on implementation of jury recommendations within a year.

(Attach additional pages if required / Joindre des feuilles supplémentaires au besoin

VERDICT EXPLANATION

re: Mitchell and Kenneth FREE-PARKIN
Deceased January 12, 1995.

I intend to give a brief synopsis of the issues presented at this inquest and to explain in some detail the reasons for the jury's recommendations. I would like to stress that much of this will be my interpretation of the evidence and also my interpretation of the jury's reasons. The sole purpose for this is to assist the reader to more fully understand the verdict and recommendations of the jury. It is not intended to be considered as actual evidence presented at the inquest, nor is it in any way intended to replace the jury's verdict.

CASE HISTORY:

These twin boys were born on October 23, 1994, approximately seven weeks premature, in London, Ontario. Their natural mother, aged 18 years, had 2 previous children aged four and two. The older child was living with grandmother, who had custody. Mother was living in a common-law relationship with a man, aged 28, who was not the natural father of the twins.

The family resided in Sarnia, Ontario, and was under a voluntary services agreement with the local Children's Aid Society (CAS) because of concerns that the infants were "at risk". The reasons included prematurity of the infants, young age of the mother, previous involvement of the common-law spouse with CAS.

In early December, 1994, the family moved to Hamilton, Ontario, and soon came under the supervision of the local CAS in that city. Assessments of the babies' risk were carried out, based on previous assessments in Sarnia, along with direct assessments in the new environment.

Over the Christmas season, the infants became ill with vomiting and diarrhea. For convenience in caring for them, they would usually be put down to sleep on the living room sofa. The normal practice would be to place them at right angles to the length of the sofa, with their heads placed towards the back support, in a prone position (ie. on their stomachs). They then would be covered up with three blankets, which would also cover their heads to a large degree.

On the evening of January 11, 1995 they were put to bed in this fashion at approximately 2330 hours. At 0500 hours on January 12, mother got up to feed them, but only one seemed fussy, so only he was fed. At approximately 1130 hours, the parents were awakened by a telephone call. Shortly thereafter, the common-law spouse noted that the infants had not been disturbed by the phone ringing.

He then discovered that one of the infants was lifeless and stiff, and the other was also very ill. Resuscitation attempts on both infants were ultimately unsuccessful.

Autopsy examinations carried out on the infants revealed enough significant findings of a nonspecific nature that the deaths could not be attributed to Sudden Infant Death Syndrome. Toxicology ruled out any suspicion of carbon monoxide poisoning, which had been raised as a concern at the time of the deaths.

Counsel to the Coroner at this inquest was Ms. Alexandra Paparella, an Assistant Crown in the Regional Municipality of Hamilton Wentworth.

Counsel to individuals and agencies granted standing included:

Mr. Alan D. Cooper
4 Hughson St. S., Ste 601
Hamilton, ON L8N 3Z1
Tel: (905) 522-0632

(family)

Ms. Kathleen Doney
50 Lisgar Crt.
P.O. Box 1170, Depot 1
Hamilton, ON L8N 4B9
Tel: (905) 387-1159 ext. 292
(Children's Aid Society)

VERDICT:

The jury concluded that the twin infants had died as a result of **SUDDEN UNEXPLAINED DEATH IN AN INFANT**, and ruled the deaths due to natural causes.

They then went on to make recommendations aimed at preventing deaths in similar circumstances in future:

To the Ontario Association of Children's Aid Societies:

Recommendation 1:
to implement a standard risk assessment tool to be used by all CAS in Ontario.

Purpose:
a. gives the immediate risk (ie. low, moderate, high)
b. helps eliminate gaps in assessment during transfer to different societies in Ontario
c. to ensure quick and appropriate action be taken

The inquest heard evidence that Children's Aid Societies in each community are independent, autonomous bodies who operate in accordance with their mandate under the Child and Family Services Act, and the standards prescribed under its regulations. Individual Societies utilize different methods and tools (procedures) to carry out their assessments of families and children to assign a "risk

assesment" so that appropriate intervention plans and action can be taken. For example, one of the CAS involved used a "Risk to Child Assessment Matrix" which scored several "Primary (Critical)" and "Secondary" risk factors, to arrive at a category rating of Low, Moderate, or High Risk for the case. This information would then be utilized to help determine the type of intervention a family required, including the number and nature of in-home visits, the degree of supervision required, or whether referral to another agency was appropriate.

This type of screening assessment tool is not universally used by all CAS, and thus the jury had concerns that there may not be standardization of risk assessment from one Society to another. This is important especially in circumstances where transfer of responsibility for supervision from one Society to another occurs. A move toward more universally accepted standards for assessment across the province by the various CAS should be encouraged by their provincial organization.

Recommendation 2:

In cases of multiple births, separate approved cribs must be used.

The family in this case had only one regulation crib in the bedroom for use by both infants. However, it was not being used, and the infants were placed on the sofa in the living room to sleep. The Hamilton CAS worker did not discuss the issue of where the babies were sleeping with the parents. The jury was concerned about the potentially less safe sleeping location for the infants, and felt that this issue should remain one of priority for Societies in the initial and ongoing assessments of home environments.

Recommendation 3:

Training role within the CAS to engender further awareness of the SIDS issue. (supine position in sleeping, overheating, maternal smoking and second hand smoke).

The inquest heard from an expert witness who was an Associate Professor of Pediatrics at the University of Toronto. Although he agreed that the deaths of the infants in this case could not be classified as Sudden Infant Death Syndrome (SIDS), the circumstances were such that multiple risk factors for SIDS existed:

- prematurity
- prone position (especially on soft surface)
- overheating due to overwrapping
- maternal smoking
- maternal age less than 20 years
- twins
- male sex.

The jury felt that the CAS, as part of its mandate, should educate and/or remind all of its caseworkers of these risk factors for SIDS

so that they in turn could enhance SIDS awareness and possible prevention in their communities.

PUBLIC AWARENESS RECOMMENDATIONS:

The jury heard considerable evidence about SIDS, the risk factors associated with it (as noted above), and how preventive measures instituted in countries such as New Zealand, the United Kingdom, and the Netherlands had significantly reduced the incidence of SIDS. These preventive measures were due largely to public awareness education campaigns carried out in the media. The jury believes that several groups or agencies should have a responsibility to bring these matters to public attention, so that similar decreases in the incidence of SIDS might be realized here as well.

Recommendation 1:

Medical education of SIDS through health care professionals. Public Health Units, Family Physicians, Pediatricians and Hospitals are to target new young mothers on recommended sleeping position, how much (or) little clothing (to use on an infant) and (risk of) smoking.

Alhough general public awareness of SIDS prevention is necessary, the jury felt that the select group of mothers with newborns would be especially important to target, as this group has the potential to make the most impact.

Recommendation 2:

Implementation of Ontario Government multi-media awareness to target the general public on SIDS

Given the success of campaigns in other countries, the jury is recommending that the Ontario Government undertake a multi-media education and awareness campaign to alert the general public to the SIDS issue. The jury was concerned that printed literature alone may not suffice in that it may not reach the population at risk. Television and radio involvement would accomplish the goal of more widespread dissemination of information. This recommendation would most likely be dealt with by the Ministry of Health, or the Chief Medical Officer of Health.

Recommendation 3:

Formal Education

SIDS awareness should be included with sex education in senior grade schools. High school parenting classes should also highlight SIDS awareness. Baby sitter courses, and care giver centres should also include SIDS in their training curriculum.

The parents of the twins had very limited education with only a few highschool credits. The jury heard that the CAS was not only

supervising care, but also giving instruction in parenting skills to them, as it appeared to be necessary. The jury feels that if such skills could be taught in other forums, and that the curriculum could easily include education on SIDS prevention strategies, future deaths could be further reduced in numbers.

Office of the Chief Coroner:

Recommendation:

to submit a progress report on implementation of jury recommendations within a year.

The jury was very attentive to the issues raised at this inquest, and would appreciate feedback on implementation of their recommendations.

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury's verdict. Likewise, many of the comments regarding the evidence are my personal recollections of the same, and are not put forth as actual evidence. Should any reader feel that I have erred grossly in my recollections of the evidence or of the conclusions of the jury, it would be greatly appreciated if that error could be brought to my attention so that it might be corrected.

Respectfully,

William J. Lucas, MD, CCFP
Coroner, Central Region (Peel)