Ontario

the Solicitor General / Ministère du Solliciteur général

the Chief Coroner / Bureau du coroner en chef

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

(97) 14952

he jury serving on the inquest into the death of: / dûment assermentés, formant le jury dans l'enquête sur le décès de:

urname / Nom de famille: HISLOP (aka) SHEPHERD

Given names / Prénom: KASANDRA

ged 3yrs / é(e) de

held at / qui a été menée à PEEL COUNTY COURT HOUSE

n the 21,22,23,24,28,29,30/1,5,6,7,8,20 / 21,22,26,27,28,29/2,3,4,5,9,10,11 / 12,16,17,18,19,20,23,24,25,26/2,3,7,8,9,10 day(s) of / (du/au) April/May/June/July. 19 97

r Dr. Bonita PORTER Coroner for Ontario, coroner pour l'Ontario.

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

Name of deceased / Nom du (de la) défunt(e): Kasandra HISLOP SHEPHERD

Date and time of death / Date et heure du décès: April 11, 1991 at 1530 hrs

Place of death / Lieu du décès: Hospital for Sick Children, Toronto, Ontario

Cause of death / Cause du décès: Craniocerebral Trauma

By what means / Circonstances entourant le décès: HOMICIDE

verdict was received by me this / erdict a été reçu par moi le 10 day of July 19 97

Dr Bonita Porter

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

1) (Rev. 00/89)

Foreword

We, the Jury, on behalf of the community of the Region of Peel wish to express our sympathy for the loss of Kasandra.

Your life was short and fragile and many people were touched by your presence. The system failed to hold your hands tightly and keep you safe. They had eyes yet they did not see; they had ears yet they did not hear; they did not look through the eyes of a child.

We are strongly convinced that concrete changes have to be done to our society's outlook on child abuse. We've put our minds together to come up with very realistic recommendations. However, we feel that these suggestions will only remain as empty words scribbled on a piece of paper if they fall on deaf ears. It is our utmost desire that our recommendations be heard, analyzed and implemented so that Kasandra may now rest in peace and that all the little ones whom she has left behind may be assured of a safe and happy home.

Recommendations
Kasandra Hislop (aka Shepherd) Inquest

Upon completion of our deliberation of the evidence presented during the inquest, the following 73 recommendations are not presented in any particular order of priority, but have been placed into categories where we felt they could be easily and best implemented.

Federal Government:

We strongly advocate that the Federal Government put children's protection, safety and well-being higher on their list of priorities. Government provide leadership and direction to the Provinces by implementing the following recommendations.

1. We recommend the Federal Government consider amending the Criminal Code to include an offense of Death by Child Abuse/Neglect.

   We recommend the Federal Government study the sentences given in child abuse cases and implement any legislative changes that would act as a deterrent and reflect society's abhorrence of child abuse without effecting the successful prosecution of such cases.

Rationale: The death of a child must be recognized as equal to the death of an adult. In their innocence, they are unable to defend themselves or escape from danger.

Provincial Government of Ontario:

Ministry of Community and Social Services

The Government of Ontario must honour their commitment and act quickly to protect the children of our society.

2. That the Section of the Child and Family Services Act dealing with the reporting by professionals of child abuse be strengthened. This could include more severe penalties, including professional sanctions as well as making special provisions to waive the 6 month limit on laying charges as prescribed under the Provincial Offenses Act.

Rationale: The above recommendation raises the level of awareness of the duty to report.

3. In a convicted case of child abuse, and the perpetrators name should be placed on the Child Abuse Register **permanently**, without the option of removal.

Rationale: Record for life. The jury feels that for the future safety of other children, names should remain on the register.

4. That the Child and Family Services Act (CFSA) be amended to ensure that the safety and rights of children are given paramount priority, and that the best interests of the child are placed before the rights of the parents.

5. That Section 37 of the CFSA relating to the child in need of protection, be amended to ensure that a child can be found in need of protection when the actions of the parent(s) or persons in a caretaking position are endangering or have endangered the emotional health of the child. This could include family violence, mental cruelty and harassment of a child and other forms of destructive parental behaviour.

Rationale: The Ontario government should consider changes to child welfare legislation to reflect a concern that neglect and emotional abuse are as significant a risk to the welfare of children as physical abuse.

6. In families with a history of abuse, there should be either permanent supervision for any children in their care or else they should permanently lose custody of their remaining children.

Rationale: In this case, evidence was heard that domestic violence can be a risk factor that leads to child abuse.

7. The Ministry of Social Services should review the guidelines for "closely monitoring". The guidelines should be amended to be more strict and more frequent.

Rationale: The jury feels that once per month monitoring may not be sufficient.

8. A permanent single interdisciplinary child death review mechanism be established provincially to conduct critical reviews of all deaths of children with particular attention to systems issues. In the event of death of a child under suspicious circumstances, an in-depth review should be conducted to include all service providers and professionals involved with the child. The results of such reviews should be widely published with particular distribution to the agencies and professional groups involved in providing service in similar situations.

9. That the Ministry work with the OACAS to develop workload standards for social workers handling the key child protection functions of Intake, Intake Supervisors, Family Services and Services for children in care. These standards should be based upon the regulations and best practice expectations, state the number of cases each social worker should be responsible for and allow the worker to have enough time to meet all the standards in each case, and include time for ongoing training and supervision.

Rationale: The testimony heard at the inquest indicated that the CAS workload directly impacts the quality of investigations. By imposing standards, the quality of child protection will improve.

10. That pending the development of an Ontario-based workload standard, the Child Welfare League of America Standards, recently adopted by the Child Welfare League of Canada, be used as a basis for funding for staffing.

Rationale: To enable children's Aid Societies to provide a good quality child welfare service.

11. That all Children's Aid Societies in Ontario implement the use of a comprehensive assessment and case planning model which includes an eligibility tool, a safety assessment and risk assessment, and an instrument for assessing parental capacity..

Rationale: Classifying a case as low risk may hamper the investigation. By implementing the use of a standard assessment tool province wide, good child protection social work judgment could be exercised.

12. That the Ministry of Community and Social Services provide appropriate support

for ongoing research and training for the implementations and maintenance of the model and that the use of these support tools be incorporated in the workload standards.

Rationale: To maintain on-going quality child protection.

13. That through the OACAS Child Welfare Training System, CAS's provide training for all new child protection workers before they are assigned any cases, and that the Ministry provide funding for this training.

Rationale: During the testimony there was an indication that more training was required for new intake workers.

14. That the Competency Based Training Program currently provided under the direction of OACAS be updated frequently with information for current research on risk identification, practices which effectively support children and families, and factors to be considered in deciding if a child should come into care.

Rationale: To maintain continued skills development .

15. That the OACAS be facilitated with an up-to-date province-wide interactive client data-base, as proposed by the Child Mortality Study.

Rationale: For immediate access to information about all active or closed cases of both the CAS with which they are associated, and of the other Children's Aid Societies across the province. This data base should also be provided to all Emergency After-hours workers.

16. Public awareness and education program
    - That a course on parenting and child development be added to the Ministry of Education's curriculum for all students grade 9 - 10.
    - That parenting courses and parenting support programs dealing with positive strategies to assist parents to avoid abusive neglecting behaviours be made readily available throughout the Region through neighbourhood centres, day care programs and parent teacher associations and other similar groups.
    - That the recommendations of the Child mortality Task Force about developing a public awareness and education program be implemented, with a focus on:
        - ⇒ the duty to report concerns about the care and safety of children;
        - ⇒ the harmful effects of child neglect and abuse, and the importance of early detection and intervention;
        - ⇒ the need for proper supervision and care of very young children
    - Prevention Services:
      That the Ministry, the Region, the United Way and CAS work together to provide easily accessible support services to young parents with

young children. Services should be based in neighbourhood and community centres, schools, or day care centres and could also be provided in the homes of the children. These programs should include parenting education in its broadest sense.

Rationale: The jury feels the public has limited knowledge of the child protection system. The responsibility of the whole community is the safety and well being of it's most vulnerable member--children.

17. That the government study, through a short-term and focused public consultation process the merits of creating a publicly-accountable, arm's length Children's Services Standards, Accreditation and Accountability Body which could:
    - accredit and license CAS's and other children's services and hold them accountable for the services they are providing and the quality of them
    - develop standards for child protections and other CFSA service with input from the practitioners in the field and experts, and provide training with regard to the same
    - promote quality assurance programs in these agencies
    - carry out any functions described in the OACAS proposal on the creation of such a body

18. That a committee be struck to deal with the issue of sharing information when investigating child abuse allegations and custody and access assessments. The membership of this committee to include:
    CPSO, CNO, OACAS, Office of the Children's Lawyer, Policing, OHA, and the Ministry of Community and Social Services, Ministry of Health, Ministry of Education, and the Ministry of the Solicitor General and Correctional Services.
    - The Ministry of Community and Social Services should take the lead role in convening this committee.

    Guidelines should be drafted and circulated until the required legislative changes are made or legislation proclaimed.

19. A report on the progress of this committee should be released in six months and at six month intervals until #18 has been implemented.

20. Confidentiality and Information Sharing:
    - a joint study between the MCSS, the Ministry of Health and the College of Physicians and Surgeons be conducted to explore the feasibility of a mechanism for the CAS and all other agencies to OBTAIN and SHARE information regarding the caregiver of a child subject to a CAS investigation in circumstances where the child may be returned to the care of that individual.

That legislation be passed outlining the CAS's authority to OBTAIN and SHARE information regarding a child subject to an ongoing CAS investigation. The goal of the legislation should be to provide the easiest and least restrictive access.

Rationale: Testimony revealed that agencies and professionals involved in the case had obtained information that was not shared among the parties involved.

FUNDING:

21. That the Ministry develop and implement a funding formula for the allocation of dollars to all CFSA and related social services (including CAS's) based on child population and social indicator factors (such as child poverty).

    - That the Ministry of Health develop a similar funding allocation formula based upon health indicators and population to provide similar access to health services across the province.
    - that the Government of Ontario take immediate steps to implement this new formula beginning in the fiscal year 1997-98 and to plan the full achievement of an equitable funding allocation across the province in both the health and social service sector within four years.
    - That the funding formula be reviewed every five years to ensure that serving vulnerable children remains a high priority and that the policy continues to be responsive and effective to the needs of these children.

Rationale: Testimony indicated Peel Region is well below the provincial standard per child. We believe that all vulnerable children and their families in need of these services may have equal reasonable and timely access to these services, regardless of where they live in the province.

22. That as part of this move towards more equitable funding, the Ministry provide all CAS's with sufficient funding each year to provide the following:

    - CAS's be funded with enough money each year to provide the full range of preventative, investigative and protections services required by the law.
    - That the Ministry should provide extra funding when there are exceptional situations or an unexpected increase in the number of cases, or there is a change in the nature of cases requiring more or different supports. If these service demands remain high over a period of three years, the extra funding would then be added to the base funding of the CAS.
    - That each CAS would be authorized to automatically hire additional staff when caseloads increase above these standards for at least three months.
    - That the CAS would be provided with ongoing funding for these workers when the volume of cases has remained at this higher level for at least 12

months.

- That once an adequate base has been established any government wishing to make cuts in the funding of children's Aid Societies must demonstrate that the proposed cuts can be made without compromising the safety of children, before imposing them.
- That the Ministry work with OACAS and CAS's to review the compensation for CAS social workers and make recommendations for improvements to support effective retention and recruitment efforts including compensation. Salaries and benefits should reflect the difficulty of the work, the responsibilities relative to other social work positions, and the consequences of the decisions and judgments made. Compensation should also reflect the value we attach to the lives of children.
- That the Ministry provide sufficient funding to Children's Aid Societies to enable them to implement these recommendations.
- That Children's Aid Societies should be funded to provide home support programs for families with children in need of protections or are at risk of being in need of protection.
- Organizations such as Peel Memorial Hospital and Peel Children's Centre be provided with sufficient resources to enable them to respond in a timely and effective manner through interdisciplinary teams of professional staff to the mental health needs of children and families within Brampton and Peel Region. These services should include sufficient psychiatrists, psychologists, and social work staff including court clinic personnel to serve the second largest region in the province.

Office of the Children's Lawyer:

A child's abode is vital to its well being. the Office of the Children's Lawyer is responsible for making accurate investigations on custody disputes and delivering appropriate decisions for such disputes.

23. We recommend the Ministry of Community and Social Service conduct a study of the feasibility of merging/incorporating the Office of the Children's Lawyer with the Children's Aid Society under one office.

Rationale: Evidence presented led us to recommend that CAS workers' scope of investigation include custody disputes and access in line with their investigation on child abuse cases. This recommendation overlaps and duplicates the mandate of the Social Workers at the Office of the Official Guardian to investigate custody dispute and access cases.
Custody Issues and Child Abuse issues are closely interrelated.
The above recommendation will help solve CAS problems on inadequacy of funds and shortage of staff.
It will also resolve confidentiality problems encountered by both agencies in their effort to disclose information on child abuse and custody dispute investigations.

24. The Office of the Children's Lawyer should clarify their role as the legal representative of the children.

Rationale: Evidence heard indicated that the role of the Official Guardian was not clear to other persons, agencies and professionals involved.

Ontario Association of Children's Aid Societies

Child protection is the responsibility of all citizens of Ontario and especially of those professionals who have regular and ongoing contact with children in the course of performing their professional services.

25. That the Competency-Based Training program currently provided under the direction of OACAS be updated frequently with information from current research on risk identification, practices which effectively support children and families, and factors to be considered in deciding if a child should come into care.

26. That CAS's, the Ontario Association of Children's Aid Societies and the Schools of Social Work jointly study the issues of staff retention in child protection work, and develop effective strategies to recruit and retain staff who are competent and challenged by the rewards and frustrations of child protection social work.

Rationale: Testimony showed there is a high turnover rate of staff.

27. That the OACAS and the Ontario Hospital Association develop best practice models for **joint protocols** between Children's Aid Societies and Hospitals to be sure that:
    - information is shared between all medical and professional staff and CAS social work staff in cases where abuse or neglect of children is suspected
    - coordinated case plans and monitoring mechanisms are established
    - the hospitals' child abuse committee are effective vehicles for communication of systematic issues between the organizations and supporters of effective and ongoing education of child abuse and neglect among the hospital staff including the medical staff
    - where police or the Children's Aid Society feel it is necessary to withhold information from doctors or hospital staff, these individuals should be advised accordingly.

    That these protocols should be part of the accreditation process for both organizations.

Rationale: There needs to be a comfortable level of disclosure of information between the two organizations. In the absence of such a model important sources of information can be overlooked.

28. That the Ministry work with OACAS and the CAS's to review the compensation for CAS social workers and made recommendations for improvements to support effective retention and recruitment efforts including compensation. Salaries and benefits should reflect the difficulty of the work.

    We recommend a study the implementation of a classification system for the

purpose of training regulation for intake workers as follows:
3rd Class (Junior): a new hire. After one year training and experience, a written exam is required to assess skills. With a passing grade, it would elevate worker to 2nd Class (intermediate), monetary compensation increased accordingly. this group handles only low risk cases.

2nd Class: (Intermediate): After 2nd year on job training/experience, a written exam is required. With a passing grade, it would elevate worker to 1st Class (senior) and be compensated accordingly. This group handles mid risk cases.

1st Class (senior): This group is the skilled and experienced worker who is assigned to handle high risk cases. The worker in this group will be assigned to assist 2nd and 3rd class workers in handling difficult cases.

Rationale: We, the Jury, recommend a study of a classification system so that CAS workers can be compensated for the level of experience, stress and the responsibilities relative to other social work positions, and the consequences of the decisions and judgments made. Compensation should also reflect the value we attach to the lives of children.

Procedure:

29. That each CAS be required to have quick access to expert paediatric advise about medical evidence of abuse or neglect.

30 That CAS implement a policy to ensure the complaint process is made known to any caregiver whose child is the subject of a CAS investigation.

Rationale: Not all caregivers are aware of this process.

31. Supervisors should routinely conduct audits of files and workers' case notes. A supervisor should as much as possible document their involvement in a file.

    A standardized provincial policy be developed about the retention of supervisory notes.

Rationale: Evidence showed there was no policy of this nature.

32. All CAS records and documentation be available to child custody/access proceedings where a CAS has been previously or is currently involved.

33. Information outlining the role of physicians in child abuse investigations should be provided to the College of Physicians by the Children's Aid Societies.

Rationale: This will clarify the role of a physician in an investigation.

34. In moderate to high risk cases, CAS must do more unannounced home visits.

Training:

35. Provide intensive training on the following:
    - Seminars on child abuse provided by Medical staff/ clarification of medical terminologies
    - Hospital protocol, mechanics of the case conference, role of Child Abuse Committee, and the child Abuse Panel, SCAN Team, Social worker Advocate
    - Investigative Procedures and Best Practices
    - More forensic documentation (including specifications of size, type, colour, area of injuries)
    - CAS workers should receive education and training with respect to accessing relevant information and documentation within a hospital.
    - CAS workers should be encouraged to access hospital records for relevant information.

36. That the Child Welfare Competency-Based Training Program provide special emphasis on the techniques and skills need to interview very young children (age 6 years and under)

Rationale: This age group is at higher risk due to their limited communication skills.

37. That the Child Welfare Competency-Based Training Program of the OACAS provide regular training all social workers staff including **Emergency After-Hours** social work staff.

38. That training be provided in the following areas which are in addition to the areas specified in the CAS recommendations:
    - risk factors especially - domestic violence and transference of feeling toward self or another individual on the child and other aspects of adult psychopothology
    - investigative interviews of caregivers with an emphasis on interviewing one at a time and recording responses to detailed set of questions
    - emotional abuse
    - monitoring - communicating with medical doctors, unannounced visits, undressing child whether high/low risk (ages 6 and under)
    - add to interviewing young children - issues related to doing interview at home, limitations in determining a child's level of fear based on limited observation
    - that CAS intaker forms include an information component identifying the

attending physician and the initial medical diagnosis

Rationale: Overall, it was apparent throughout the evidence further education and training is required on the above matters.

39. Custody and access - there should be recognition that custody and access dispute cases merit as full an assessment for suspected child abuse as cases without this feature

Rationale: Evidence was heard that in custody and access disputes child abuse allegations may be investigated differently from other cases of abuse allegations.

College of Physicians and Surgeons

The health care that our children receive from the medical profession is invaluable. As the level of child abuse awareness increases, the medical profession plays an important role to ensure that child care system works effectively.

General:

40. Efforts should be made to increase the number of physicians/paediatricians with an expertise in the area of child abuse in order to support the recommendation dealing with medical supports for the CAS. This should be available throughout the province.

41. Knowledge of child abuse should be a requirement for medical licensure in the province.

42. The CPSO should regularly send information to physicians on the duty to report and should include information on all forms of child abuse.

43. Where a physician reasonably suspects child abuse, all relevant information obtained during the history and physical examination should be thoroughly and accurately documented including location, age, description, and the explanation given for the injury if possible indicate if the injury is consistent with the explanation provided.

Rationale: Testimony showed it was important to accurately chart patient information and where differences occurred; further investigation is warranted.

44. A physician referring a patient to a specialist should communicate personally and/or in writing to the specialist:
    - the reason for the referral
    - any relevant medical information known to the referring physician
    - which physician will provide ongoing care to the patient for the presenting problem
    - In any case a written report from the treating physician should be made to the family physician

Rationale: Evidence was heard that information was not provided by the referring physician, information was provided by the parent.

45. In all cases of suspected physical abuse the child's CT Scan should be reviewed by a paediatric neuro radiologist or a radiologist with an expertise in

child abuse. A paediatric network, similar to the one being developed in Metropolitan Toronto, should be set up covering all regions to facilitate this process. This recommendation should be sent to the CPSO.

Training:

46. There must be mandatory training In medical schools on the recognition and assessment of child abuse. This must include workshops and hands-on experience in handling child abuse patients.

47. Physicians should receive training on accurate documentation of injuries including the specific area, size, colour and type of injury, whether or note the case is deemed "reportable".

48. Training should be made available in the area of forensic investigation of child abuse for physicians specializing in family practice, emergency medicine and pediatrics.

49. There must be mandatory education of physicians on the duty to report: Information should be distributed to health professionals in the professional training, in continuing education programs, through professional organizations, and through any other available means that clearly and accurately outlines the full scope of the duty to report. Such training should be included in academic institutions as well as through professional associations as part of continuing education.

50. That medical practitioners receive training on domestic violence and the increased risk it presents for child maltreatment.

Rationale: The above recommendations on training coincides with the recommendation to place the child's welfare first and foremost.

51. The CCFP and College of Physicians and Surgeons develop guidelines for family doctors in situations where their professional objectivity may become clouded. In particular where the physician is responsible for the care of one or more family member, potential conflict of interest needs to be examined where there is domestic violence and/or suspected child abuse.

Rationale: Such a conflict may interfere with an accurate diagnosis and obtaining the best possible treatment for all parties involved.

Paediatrics:

52. The CCFP and the Canadian Society of paediatrics should receive the facts of Kasandra's case to be used as a learning tool and the issues to be highlighted include:

- the importance of providing the radiologist with a medical history
- the diagnostic dilemmas
- the need to specify what is anticipated the diagnostic imaging will detect
- interpreting the CT Scan in light of the clinical symptoms
- the significance of cerebral atrophy in a child
- the limitations of diagnostic imaging in ruling out a head injury
- emotional abuse

Ontario Police College

53. That the OPC require testing of officers' knowledge relating to child abuse investigations.

Rationale: Evidence heard suggested the knowledge relating to child abuse can be improved.

Peel Regional Police

54. The Sexual Assault/Child Abuse Coordinator for the Peel Regional Police develop a standard form to be utilized by all officers when commencing an investigation into suspected child abuse. This form would include an anatomical sketch, an observation section, an area to list family members and if the child is in hospital, the attending physician's name and initial diagnosis shall be recorded.

Rationale: In 1991 there was no consistent way of documenting such investigations.

55. The Child Abuse Protocol compiled by Peel Regional Police, Peel Children's Aid Society and Peel Crown Attorney's Office dated Feb. 1994 should be revised to include Physicians and hospitals in the Peel Region.

Rationale: It was evident that in 1991 agencies involved in child abuse investigations did not have a clear understanding of each others roles and responsibilities.

56. It is recommended that on the onset of a child abuse investigation where evidence is insufficient it is preferable to initially conclude such case as "unconfirmed" rather than concluding it as "unfounded".

Rationale: To initially conclude a case as "unconfirmed" as opposed to "unfounded" opens more avenues for investigation and may eventually lead to substantial evidence.

Peel Children's Aid Societies

57. The CAS should require the Child Abuse Panel to promptly review any case where there are three complaints or referrals received.

Rationale: "Repeat investigations" should serve as a red flag to indicate the case is a serious matter for further investigation.

58. "Duty to Follow -up":
Must be the primary responsibility of CAS while child abuse investigation is on-going. Persistence is required from CAS worker until substantial information is gathered.

Rationale: Evidence was heard that it was unclear to all parties who was the designated person/agency responsible in follow-up.

59. All possible sources of information for a child abuse (custodial and non-custodial) case must be accessed and interviewed by the CAS worker.

Rationale: In this case the biological mother was not interviewed.

60. Fund Raising: CAS could be more aggressive, creative and raise level of awareness in fund raising efforts.
CAS could perform an annual nationwide campaign on child abuse - seeking corporate sponsorship.

61. CAS should notify day care of the child abuse investigation.

College of Family Physicians

62. Certification of family Practitioners should include training and assessment of candidates ability to identify abuse and neglect, and their knowledge of duty to report; role of family physicians in dealing with domestic violence; issues of objectivity when acting as physician for the entire family; and importance of accurate documentation when assessing injury.

Rationale: Often, the family physician is the front-line medical practitioner that a child will see. We heard evidence that there is minimal training in the area of child abuse and domestic violence.

Peel Health Department

63. That CAS and Public Health work together to clarify roles that each party will play in the prevention of child abuse.

Hospitals:

64. That there be a policy that in a case of suspected child abuse that the discharge summary be available for the CAS prior to the child's discharge.

Rationale: Evidence indicated the discharge summary was completed June 10, 1991. The delayed summary can be of minimal purpose or value.

65. That the General Hospitals in each jurisdiction develop a set of protocols with Regional SCAN teams and that these be made known to the Children's Aid Societies so all parties concerned are aware of what resources may be used in what circumstances.

66. The Ontario Hospital Association should revise and update its July 1987 Child Abuse Manual and include guidelines for a suspected child abuse form that includes direction to note size, shape, colour, age of bruise or other injury.

67. The Ontario Hospital Association consider including child abuse training and expertise as components of the hospital accreditation process where the hospital is providing services to children.
The Ontario Hospital Association should allocate funds to carry out such recommendations.

Peel Memorial Hospital:

68. Case Conference:
Improvements recommended in conducting hospital Case Conference as follows:
- a formal meeting agenda should be carried out
- a chairman and a secretary to record minutes must be assigned
- a list of attendees must be prepared, contacted and required to attend the conference. List of attendees must include all professionals and representatives of agencies involved in the child abuse case.
- Office of the Children's Lawyer to attend case conferences at hospital as well as Child Abuse Committee in cases of suspected child abuse when custody and access are being assessed
- the entire meeting must be tape recorded and minutes must be presented in a professional format and approved by the chairman
- in the absence of the professional or representative, a written report of medical findings/investigation findings must be provided to the case conference
- the family history of patient must be provided by the Family Doctor

- copies of the minutes of the Case conference must be sent to all parties involved in the case within 48 hours
- all differential diagnoses must be discussed, explained and resolved at the end of the Case Conference
- Plan of Action to be carried out must define clearly the role of each professional/agency involved
- The case Conference must reconvene after a reasonable period of time to review how plan of action is working out and implement changes if needed

Rationale: Evidence was heard that there was a need for improved organization, attendance of all parties with relevant information, and improved documentation to ensure optimum communication and a clear and appropriate plan of action.

69. Child Abuse Committee:
We recommend the Child Abuse Committee must have a more active role in area of child abuse evaluation.
The Chairperson on the Child Abuse Committee should delegate someone to see the child upon receipt of the suspected child abuse report (within 24 hours).

Rationale: The role played by the Child Abuse Committee was not clear in the testimony heard.

70. Child Psychiatrist::
We recommend the hospital to acquire on staff a child psychiatrist specializing in the treatment of children ages 12 and under.

71. Emergency admission procedure should include notification of the family doctor upon admission of a suspected child abuse patient.

Other

72. The Office of the Chief Coroner should convene a press conference one year from the day on which the jury releases its recommendations to provide an update on the implementation of the jury's recommendations.

73 The jury's verdict and recommendations should be forwarded to all medical schools and teaching hospitals in the Province of Ontario.

VERDICT EXPLANATION
KASANDRA HISLOP (AKA SHEPHERD) INQUEST

APRIL -JULY 1997

OLD PEEL COUNTY COURTHOUSE
BRAMPTON, ONTARIO

I intend to give a brief synopsis of issues presented at this inquest and 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 and is not intended to be considered as actual evidence presented at the inquest. It is in no way intended to replace the jury's verdict.

The inquest began on April 21st ,1997 and the jury returned their verdict and recommendations on July 10th, 1997.

Coroner's counsel were Ms. M. Ward and Mr. M. Saltmarsh.
Parties with standing were:

Regional Municipality of Peel- counsel - Ms. M. Wiggan
Peel Regional Police - counsel - Mr. K. Harris
Peel Memorial Hospital - counsel - Mr. M. McKelvey
Peel Children's Aid Society - counsel - Mr. M. Hartrick
Physicians - Drs. Chiang, Muhtadie, Mehrmanesh, Lam, Jeeva, Lau and Greenaway - counsel - Mr. S. Mason and Ms. J. Stephenson
Amanda (Hislop) Gribben
Ashley Shepherd
Maria Shepherd - counsel - Mr. S. Kovacs

Investigatating officers: - OPP Det. Insp. J. Goodlett
Det. St.Sgt.M MacLachlan
Det. C. Brenda Thomas

Coroner's Constables: Const. M. Carlson
Const. B. Rands

Court Reporter : Ms. Jean Savage (Abbot Professionals)
(905)457-8880

Kasandra Hislop was born on December 15, 1987 in Mississauga, Ontario. Her parents separated shortly after her birth and she resided with her natural mother until November 1989 when a family court judge awarded interim custody to the natural father and his wife.

Prior to November 1989, there were two reports to police and children's aid. One alleging abuse regarding a mark on Kasandra's arm, (determined to be " unfounded"), and one concerning poor living conditions and leaving Kasandra alone (parent was cautioned).

In May of 1990, there was a report to the CAS and Police of a possible sexual assault on Kasandra. This was investigated by speaking to Kasandra, the natural father and stepmother, and by physical examinations by the family physician and a pediatrician. The person who was alleged to have committed the assault was not interviewed. The allegation was felt to be "unfounded".

In July of 1990, a family court judge ordered the Official Guardian to do a custody assessment. A social worker was assigned to the case in September of that year. Interviews and home visits were conducted with both natural parents, the stepmother and boyfriend of the natural mother. The assessment was suspended while Kasandra was in hospital and the CAS were involved.

During this time, the family physician was seeing the family who had custody of Kasandra. There were reports of domestic violence, suicidal ideation and depression. A counseling appointment was made for the patient with these complaints, but not kept.

In Sept of 1990, Kasandra was brought to the family physician with small red dots around her face. These were diagnosed as "petechia" and blood tests were ordered. The custodial parents did not have those tests done.

Kasandra had been attending daycare up until January of 1991. In that same month she was taken to see the family doctor with complaints of a rash, loosing hair, poor appetite and not being friendly to her stepmother.

On Feb. 1 while at her natural mother's for an access visit, bruises and a black eye were noted and reported to the police and children's aid. These were investigated and determined to be "unfounded".

On Feb. 11, Kasandra was taken to the family physician by her father and stepmother with complaints of poor appetite and vomiting. There were bruises over her face and body, and the physician determined her to be dehydrated.

He told the parents to take her home. A pediatrician was consulted by telephone and it was decided to have blood tests done and she would be assessed the next day. Her parents were asked to return to the doctor's office to pick up a requisition for the blood tests. They were told by the family physician to take her to hospital if the vomiting continued.

The family took Kasandra to the lab in the evening and the blood test results were phoned to the doctor's office around 8:46 pm.

The vomiting continued and Kasandra was taken to the Emergency room of the local community hospital. According to the emergency room record, her blood pressure was 112/50, pulse 110, respirations 28 and temperature 36.9C.

The nursing notes from the emergency room record were made at 2215. The chief complaint as told to the nurse by the stepmother was vomiting ++ and some diarrhea. It was recorded that some blood work had been done that night and was normal. There was a history recorded of decreased appetite and activity for one month. Diarrhea for two days and then vomiting with little intake and lethargy for two days.

The examination as recorded by the nurses indicated an alert but lethargic child. Dark circled eyes and dry skin. Query a bump on the right parietal skull and several old bruises to body and face.

The emergency room physician was told by Kasandra's father that the bruises had appeared 3 days earlier, the child had been vomiting and had diarrhea. The father advised there was a custody battle ongoing, however, the natural mother had not seen the child for 10 days.

On examination, the emergency room physician found Kasandra to be dehydrated, and lethargic. Fundi were examined and reported as being normal. Bruises were noted and recorded on her face, back of the head, back and tops of both feet.

The diagnoses of dehydration and possible child abuse were made. The pediatrician on call was consulted (the same pediatrician who spoke to the family physician earlier that day). Kasandra was started on IV fluids and admitted.

The suspicion of child abuse was noted and recorded on a "Suspected Child Abuse Report" form as per hospital policy and the children's aid were notified.

Blood work (CBC, Electrolytes, BUN, glucose, amylase, PT/PTT, Hgb electrophoresis, blood smear) urine R&M, along with skull xrays and a CT scan were ordered. No abnormalities were noted in the laboratory tests.

The Skull Xray was reported as:

> "The bones of the calvarium are normal. The pituitary fossa is normal.
> Impression: Normal Examination."

The CT scan was done Feb. 12th and was reported as:

> " A plain scan was done. There is definite evidence of a very prominent sulci and the ventricles are also slightly dilated for this age. The appearances are consistent with that of cerebral atrophy. I do not see any evidence of a subdural hematoma present. No abnormality is seen."

The police and a CAS worker attended the hospital and interviewed Kasandra, the natural father and stepmother and the family physician. Based on those interviews, the police closed their investigation. The CAS worker testified that she intended to stay involved.

Kasandra gradually improved in hospital. Initially she was withdrawn and wanted to spend most of her time in bed. According to the nurses notes, vomiting continued until February 22nd.

Conflict occurred between the parents in the hospital and a consultation was obtained from social work, psychiatry and a second pediatrician.

Throughout her hospital stay, Kasandra gave conflicting statements as to who was hitting or spanking her. She implicated both natural parents and stepmother to different staff at different times.

Two case conferences were held to discuss Kasandra's case. One was held on Feb. 27th and at that time according to the minutes, persons attending expressed concern about " the child's future". The summary is recorded as " ....This is emotional abuse as well as physical abuse. ..The plan of action: Further investigation of the family situation is warranted."

A further conference was held on March 6 where all caregivers attended. Conflict among the parents was evident and allegations of domestic violence were denied. The summary is recorded as: "Parents to stop the emotional bruising.....". The plan of action: " CAS to monitor both outside and inside the homes..... . Reports or changes were to be reported to the family physician. All caregivers were to go to the family physician if problems arose."

Kasandra was discharged on March 8,1991.

A post-discharge appointment with the attending pediatrician was kept on March 21st. Kasandra was noted to be doing well.

A follow-up appointment with a neurologist was scheduled for April 01st. Kasandra's father attended, taking with him the CT scan. According to the information recorded in the consultation note , the specialist was advised that the bruises on the recent hospital admission were self- inflicted. No information was provided to the neurologist about other aspects of the hospital stay. The neurologist suggested the cerebral atrophy may be attributed to her dehydration status on admission and suggested a repeat CT scan when she had returned to normal. No CNS abnormalities were found.

A psychiatric appointment for the stepmother was not kept and the family physician was notified of this.

Following her discharge, Kasandra was seen by the family physician on March 22. The complaint at that visit was that she was picking at herself and had sprained her ankle. There was information given that the father and stepmother were fighting. There is a picture of a face in the physician's chart showing " scratches" and a picture of buttocks showing 4 spots and noting " bruises?". The diagnosis at that visit was " dysthymia , anxiety and ? depression secondary to behavioral disorder." The plan was to monitor the child in the office in one week's time.

On that same day, the stepmother complained to the family physician that the family was breaking up and Kasandra was rejecting her.

The CAS worker visited the home on March 25, 1991 and no problems were identified.

On March 27th, Kasandra saw the family physician again. The information in the chart indicated incontinence of urine , decreased appetite and weight loss. Appointments were noted for the psychiatrist (this was not kept) and the neurologist (this was kept).

On April 2nd (one day after the neurologist appointment), a public health nurse visited the home to check on the stepmother and a new baby, and phoned the CAS worker to advise that Kasandra was withdrawn and not eating. The worker was not in at the time and a message was left with a secretary.

On April 5th, the same public health nurse phoned to say that the stepmother and father were doing well but Kasandra was starting to deteriorate. That same day, the stepmother called the worker to advise that Kasandra was losing weight and not eating properly and that the family doctor was monitoring.

On April 8, the family physician was advised by the stepmother that Kasandra was throwing up again and perhaps she should go live with her natural mother. On the 9th of April, the natural mother received a call from the stepmother advising Kasandra could come and stay with her. Later that evening 911 was called as Kasandra was having a seizure. She was taken to the local hospital and then

transferred to the Hospital for Sick Children. A head injury was diagnosed and life support was withdrawn on April 11, 1991.

Following a police investigation and during a trial the stepmother plead guilty to manslaughter and was sentenced to two years less a day.

On admission to the Hospital for Sick Children in April of 1991 the original CT scan of Feb. 12 was reviewed. The opinion that there was evidence of a possible head injury at that time was given. At the inquest, a pediatric radiologist was consulted. The report given at that time was:

> " The CT scan from 12-02-91 demonstrates a slightly widened subarachnoid space anteriorly. No definite blood is seen in this area, however, a chronic subdural cannot be excluded. The ventricular system is at the upper limits of normal. There is a region of homogeneous attenuation thickening the right tentorium. This has the appearance of a subacute/chronic subdural hematoma.
>
> No other intracranial abnormalities...."

The autopsy findings indicated a recent and a remote head injury. While the dating of the previous head injury could not be entirely specific the pathologist indicated through the expert witness that the findings were consistent with the report of the CT scan given by the pediatric neurologist at the inquest.

The expert witness, Dr. Marcellina Mian of the SCAN team of the Hospital for Sick Children, attended three days of testimony and testified at the end of the inquest having reviewed all of the documentation. Her opinion was that clinically, Kasandra presented with symptoms of a head injury in Feb. of 1991. Problems with information sharing and a clear understanding of roles were identified. Dr. Mian testified about risk factors in child abuse including domestic violence.

The jury sat through 34 days of testimony and 56 witnesses. Evidence was presented by children's aid workers, police officers, nurses, social workers, child care workers, physicians, representatives from the Ontario Association of Children's Aid Societies, the worker from the Office of the Official Guardian,

hospital administration and the Ministry of Community and Social Services.

Their verdict contained 73 recommendations directed to the following agencies:

Federal Government
Provincial Government- Ministry of Community and Social Services
Office of the Children's Lawyer
Ontario Association of Children's Aid Societies
College of Physicians and Surgeons
Pediatric Specialists
Ontario Police College
Peel Regional Police
Peel Children's Aid Society
College of Family Physicians
Peel Health Department
Hospitals and particularly the Peel Memorial Hospital
Office of the Chief Coroner

The jury has provided a rationale for their recommendations which I believe fully explains how they arrived at them.

If any further information or further details are required to help understand the clinical issues I would be happy to provide them.

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 verdict. It is worth repeating that it is <u>not</u> the verdict. Likewise many of the comments regarding the evidence are my personal recollection of the same and are not put forth as actual evidence. IF any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention and I will gladly correct the error.

Dr. Bonita Porter
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