THE ROLE OF THE CORONER IN THE DETECTION
OF CHILD ABUSE AND NEGLECT

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ABSTRACT

The role of the Coroner in child protection is examined from the creation of the office in Medieval England to the current B.C. Coroners Service. Legislation and policy of the Coroner and Ministry of Social Services are examined with regards to investigating deaths of children. An exploratory, descriptive review was conducted of the B.C. Coroner’s files for 1986 to 1989 to identify abuse and neglect deaths. Thirty-five child abuse and neglect deaths were identified. Ministry of Social Services files were searched to determine if there were prior child welfare investigations. Results indicated these had been conducted in 14 of the cases. Five children had been apprehended and returned prior to the incident causing death. Victims and perpetrators were similar to those of other studies. Children under the age of 5 account for 80% of the victims, slightly more males than females were killed, and parent or parent substitutes were identified as the perpetrator in 74% of the deaths. Training for Coroners, social workers, police and medical staff dealing with possible child abuse and neglect deaths is recommended. It is recommended that the Coroner review all deaths in which M.S.S. had, or should have had, any involvement. The Coroner has and continues to play a valuable role in detecting child abuse and neglect, and in educating agencies and the public.
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INTRODUCTION

The office of the Coroner is one of the oldest common law institutions dating back to the reign of King Alfred (871 -899 AD) (Boys, 1893). The Coroner is mandated to investigate the circumstances of death and to determine why the death occurred. The mandate of the Coroner is based on the principle that the death of an individual is a public fact and the circumstances surrounding the death are of interest in protecting other members of society (Cain, 1988). Information gathered by the Coroner during the investigation of deaths is used to identify concerns and make recommendations to protect the living (Granger, 1984).

Knowledge about child abuse and neglect is an historically recent development. Dr. Henry Kempe and his associates are credited with bringing the issue of battered children to the attention of the public and professionals in 1961 (Pelton, 1981). Helfer and Kempe recognized that the Coroner had published material detailing the evidence of the neglect and abuse of children found during autopsies as early as 1661 (Helfer and Kempe, 1987). Coroner’s files have been used by contemporary researchers to examine child abuse and neglect deaths. The most notable example is Greenland’s 1987 study of deaths in the U.K., the U.S.A. and Ontario.

The examination of child abuse and neglect deaths has implications for the field of social work in that identifying who is killed, and who kills, allows for the provision of services to the most vulnerable to minimize further deaths. In the present study the use of the Coroner’s files to examine child abuse and neglect deaths
illustrates cases in which child welfare services may have not been offered, been inadequate or rejected by the parent(s). The results illustrate the need for the training of social workers dealing with high risk situations, and for police officers and Coroners investigating child abuse and neglect deaths. The data indicates that children are vulnerable and when their families are not able to protect them the state must act to do so. The findings support the need for child protection legislation, policy and practice to focus on the child as the primary client.

The incentive to write this thesis came out of eleven years of child welfare practice as a social worker and supervisor for the Ministry of Social Services in B.C. I have investigated child abuse and neglect cases in urban and rural areas in North Central B.C. I have worked as a social worker in the Vancouver After Hours office at the Helpline For Children and as a social worker on Car 86 (M.S.S. social worker and Vancouver City Police officer working out of an unmarked police care and responding to child welfare concerns and situations of domestic violence). I spent four years as the District Supervisor in the most northern office in the province serving a geographically large and isolated area. In the course of my social work career I have conducted over a thousand child welfare investigations, seen every manner of abuse and neglect inflicted on children, been consulted on child abuse deaths, and investigated near deaths and deaths.

Based on experience in the field I have developed a style of social work that can best be described as a systems based feminist approach to community centred practice. In systems theory the sum of the whole is greater than the parts. Each part influences the system and thus a child cannot be dealt with in isolation of their
family, nor the family from the community. The least empowered members of our social system are women and children. Their ability to protect themselves and to influence change in the greater system is hampered by their lack of power. A community is unlikely to respond to the needs of its most vulnerable members if information about the risks they face is not shared. Thus social workers must work within the system of the community gathering and providing information to strengthen the ability of the community and family to protect children. At times the child is not adequately protected and death may occur. When a child dies of abuse or neglect the social worker, family and community must be prepared to examine the reasons why.

The investigation of near deaths and deaths lead me to explore the question of "Why are children killed as a result of abuse and neglect, who kills them and how?" I then began to ask what had been learned from the deaths of children and how the information was being used to protect those who are living. My questions lead me to the office of the Coroner for the Coroner is charged with asking "Why did this person die?" and providing information and recommendations to the community to prevent further deaths.

I found that despite the availability of the Coroner's files for research little has been written on the role the Coroner has played in detecting and preventing child abuse and neglect deaths. The intent of this thesis is to examine the historical development of the Coroner to its present format, and the mandate in B.C. in the area of child abuse and neglect deaths. The B.C. Coroners Act is examined to demonstrate the mandate and power of the Coroner to investigate deaths. Policy of the B.C.
Coroners Services and the M.S.S. is examined with regards to the deaths of children. This review is provided in Chapter 1.

The research portion of the thesis consists of a four year review of the files of the Coroner for the Province of British Columbia. Permission was obtained from the Chief Coroner of the Province, Mr. J.V. (Vince) Cain to examine in detail the files of all of the deaths of children investigated by the Coroner from 1986 to 1989 (inclusive) to identify probable child abuse and/or neglect deaths. Permission was obtained from the M.S.S. to determine if the children and their families identified from the Coroners file had ever received services from the M.S.S..

The research took the form of an exploratory, descriptive study to determine who had died, at whose hands and by what means. Prior abuse and/or neglect, and the knowledge of risk to the child before the death were explored. Data sources used by the Coroner and the provision of services by the M.S.S. were noted. The methodology is described in Chapter 2.

Results from other studies using Coroner’s files as a data base were then compared to the present results obtained from B.C. Coroners Service files to determine if the findings were similar. Analysis was done of four cases in the present study to illustrate the differences seen in inquests.

Results indicate that the child abuse and neglect cases investigated by the Coroner in B.C. for the years of the study were similar to those investigated by Coroners in other jurisdictions. Parents and caregivers were found to be responsible for the greatest number of deaths. Boys and girls were killed in almost equal numbers with children under the age of five being the most vulnerable. Children were killed
in a variety of ways with the majority of the deaths appearing to have been planned and intended. In some instances the adult appears to have responded to the frustration of caring for the child by shaking and hitting without the forethought that their actions might cause the child's death. Five of the deaths occurred in conjunction with the sexual assault of female children. The results indicate that the Coroner has the ability to gather information on the life and death of the deceased from a wide range of sources. While the Coroner appears to have utilized many sources of information the M.S.S. appears to have been overlooked as a potential source of data in almost one third of the deaths. The lack of notification to M.S.S. resulted in potential information not being utilized in the inquiry or inquest in some of the deaths. In six cases the lack of notification resulted in the risk to surviving children in the home not being assessed. The oversight raises the concern that the circumstances of the child's death may not have been completely investigated, and that child abuse and neglect deaths may not have been recognized. The oversight also raises the concern that despite a child in the home dying under circumstances indicating that abuse and neglect were factors in the death the risk to the other children was not assessed, leaving them potentially at risk. Results of the study are presented in Chapter 3.

Historically the Coroner has played an important role in the recognition of child abuse and neglect deaths. The Coroner continues to play an important role in the detection of child abuse and neglect deaths and is an important component of the overall child welfare system. The answers found by the Coroner when responding to the question "Why did this child die?" need to be incorporated into the overall plan
to protect children in B.C. Without the inclusion of the Coroners findings the child welfare system may not learn from the cases in which the system has failed the very people it was designed to protect. When the information is incorporated and acted on it is possible that fewer children will be the ultimate victims of child abuse and neglect. The office of the Coroner will then have fulfilled its mandate, for the investigation into death to contribute to the protection of the living. Chapter 4 details the conclusions reached and recommendations made.
CHAPTER 1

LITERATURE REVIEW

The Coroner: An Historical Overview

The bulk of the literature on the subject of child abuse gives the impression that the physical abuse of children was not recognized until the advent of medical technology in this century. The history of the Coroner illustrates that the intentional abuse of children was recognized and documented long before the invention of X-rays, Caffey's (1946) work on the fractures of the long bones in children and the publication of Helfer and Kempe's The Battered Child in 1962.

Records of the Coroner date back to the twelfth century and illustrate that children have been physically and sexually abused and neglected to the point of causing death for as long as the issue has been documented. Child abuse is not a new issue, it is simply an issue that we as a society have only begun to recognize in the last half century. The history of the Coroner's office raises the question of why society did not heed what was being documented centuries ago and makes one wonder how valued children really are. To understand how the Coroner came to be involved in the investigation of death it is necessary to examine the origins of the Coroner and how the original intent has altered over time.

The origins of the office of the Coroner are shrouded in history. Although recognized as one of the oldest common law institutions in English law (Cain, 1988) the exact origins of the office are unclear (Boys, 1893). References are found as early as the reign of King Alfred (871 - 899 A.D.), and in the charter of Athelstan to
Beverly, anno 925 (Boys, 1893), but most historians relate the origins to the English Articles of Eyre in 1194 under the reign of Richard 1. The Statute of Westminster in 1275 was the first detailed statute concerning the Coroner. The De Officio Coronatoris of 1276 outlined many of the duties of the Coroner’s office (Marshall, 1980). The office was intended to provide a balance to the powers held by the sheriff between eyres, or sittings of the King’s court, and to ensure that revenues were collected and paid to the Crown according to the laws of the day (Granger, 1984).

Early coroners received no pay for their duties, but were exempt from all "juries, assizes and recognitions" (Marshall, 1980). To guard against the coroner pilfering from the King only knights could be appointed to the position as the knight was assumed to have the financial means not to need to steal from the king and the moral basis to resist the temptation (Boys, 1893). The requirement of knighthood was discontinued in the fourteenth century as the office lost social stature and importance (Marshall, 1980).

The Coroner was known as "Coronarius" in the reign of Richard the First. During the reign of King John the coroner was called "custos placitorum coranae" and later "Coronator, while in the time of Henry 11 the term "Serviens regis" was used (Boys, 1893). The original meaning of the term "custos placitorum coranae" was keeper of the plea of the Crown and later transformed to the present day term of "coroner"(Granger, 1984).

The first clearly documented use of the office of the Coroner was by King Henry II who used the Coroner as a means of extending "the royal control over justice and local government, affording increased opportunities for the effective
collection of revenue" (Granger, 1984). The office of the Coroner was utilized to promote the centralization of justice in England during King Henry II’s reign (Marshall, 1980). The King’s court attended communities on a visiting basis, from yearly to once every three years. In the absence of the court the Coroner gathered information and reported to the King. Pleas to the Crown were "kept" as the Coroner could not conduct a criminal trial, but rather had the authority to hear the plea and in effect remand suspects until the next sitting of the King’s Court (Granger, 1984).

The Coroner had authority over the finding of treasure trove, ship wrecks, royal fish (sturgeon and whales), felons seeking sanctuary who volunteered to seek exile, hearing private accusations of crimes and confessions, arresting suspects or witnesses and appraising and protecting property that might be forfeited to the King under the mandate of the Coroner (Granger, 1984: Cain, 1988 and Marshall, 1980).

The modern day inquest is a carry over from the early functions of the Coroner. The De Officio Coronatoris of 1276 mandated the Coroner to investigate deaths to determine "where the person was killed, who the person was, who was present" (Marshall, 1980) and in theory who was guilty of causing the death. The primary interest of the Coroner was to ensure that any monies due the King as the result of the death were paid. In Medieval times the King was entitled to money from all but natural deaths. A murder saw the King collect the goods and possessions of the guilty party, in the case of a suicide the estate passed to the King; and in accidental deaths the King "received as a deodand the object causing the death" (Marshall, 1980).
Deodands were originally to be dedicated to the Church "expiating their sin," but in time the deodand came to be viewed as another source of revenue for the Crown. Deodands were not abolished in England until 1846 (Granger, 1984).

The office of the coroner was responsible for establishing "Englishry" (that the deceased was a Norman and not a Saxon or foreigner). After the conquest of Britain the Normans imposed heavy fines on Saxon towns where Normans were found dead of other than natural causes to prevent a recurrence. (The assumption was that the Saxons had caused the death of the Norman, and if their activities were not curtailed all Normans would potentially be at risk.) The levy, "lex murdrum" was in time applied to any suspicious death unless it could be proven that the deceased was not Norman and in fact was Saxon. (Granger, 1984). Failure to report deaths resulted in fines being levied against the whole town where the body was discovered to ensure that the King received compensation for the death. The fines for not reporting a death were so severe that in time the procedure to report became formalized. Thus what had begun as a means of apprehending the killers of the conquering Normans evolved into an efficient way to collect money for the monarch. (Marshall, 1980). The collection of the "lex murdrum" continued until 1340 when it ceased to be a source of revenue for the Crown (Granger, 1984). The legal requirements to report deaths continues to this day in the Coroners Act.

Procedures relating to the inquest developed with usage (Marshall, 1980). The law was clear that the finding of a body must be reported. The first person upon the scene was expected to "raise a hue and cry" (Granger, 1984) to notify others and to cause the Coroner to be brought to the scene. Due to the financial hardship imposed
Coroner/Child Abuse

on a town if a non-accidental death occurred in the vicinity Granger suggests that it was not unusual for the body to be moved to another locale. In time the moving of the body was expressly forbidden (Granger, 1984) and remains forbidden in modern law.

Upon attending the scene the coroner summoned the jury. The jury was originally made up of all men (males over the age of twelve) in the four neighbouring towns. The jury was sworn and the inquest held "super visum corporis" (upon view of the body) (Marshall, 1980). The Coroner and jury examined the body and the circumstances of death. The jury was expected to not only rule on the cause of death, but also to provide information as to who the deceased might be and how they met their death. Who had died, when, where and by what means was recorded by the coroner on the Rolls of the Coroner. The information was presented at the next sitting of the King’s court in the area and any payments owing from the death were made to the Monarch at that time (Granger, 1984).

The size of the jury decreased over time, from all men of the four neighbouring towns, to twenty-four, and later, to twelve men. Until the seventeenth century the jury served as witnesses and as a finder of facts. As the number of inquests increased and the questions became more complex the role of the jury became limited to the current role "of a finder of fact rather than a source of evidence" (Marshall, 1980). In 1835 John Imprey wrote a manual for Coroners and advised swearing an odd number of jurors to avoid a hung jury (Marshall, 1980). The practice continues to this day in some jurisdictions.
The powers and duties of the Coroner were eroded as the English legal system began to change in the Middle Ages. The positions of the escheator and keeper of the peace (later the Justice of the Peace) appeared and usurped many of the functions of the Coroner and led to a decrease in the power and prestige of the office (Granger, 1984). The discontinuation of the requirement of knighthood in the fourteenth century to hold the office led to an even greater reduction in the prestige of being a Coroner.

The practice in Medieval England was to investigate all violent deaths which occurred under suspicious circumstances (Marshall, 1980). When the statute of 1487 was passed provision was made to pay the Coroner for investigations into felonious crimes, but not for deaths by misadventure leading the coroner to concentrate on felonious deaths. Further legislation in 1509 made it a fineable offence for a Coroner to claim a fee for holding an inquest into a death by misadventure. The Coroner’s role had become to be viewed as "primarily significant for criminal investigation purposes" and less as a mean of investigating death by misadventure or collecting revenue for the Crown (Granger, 1984).

There were few changes in the office of the Coroner from the fifteenth to the eighteenth century (Cain, 1988). Statutes were passed in 1738 and 1751 to increase the Coroner’s fees from the levels set in 1487, but little change was made in the Coroner’s practice (Marshall, 1980). The Coroner’s "right and duty" to hold an inquest into an unexplained or sudden death was restated in Common Law at this time (Cain, 1988).
The introduction of two pieces of legislation in 1836 in England advanced the office of the Coroner. A Births and Deaths Registration Act attempted to account for every birth and death in England and Wales. The second Act provided for the payment of medical witnesses at the inquest and for an autopsy ordered by the Coroner or majority of the jurors (Marshall, 1980).

Legislation was passed in 1837 which enabled the Coroner to collect medical fees and "all reasonable expenses incurred in connection with inquests" (Granger, 1984). The holding of inquests was hampered at times as the Coroner had to collect his fees from the Justice of the Peace or Town Council who viewed limiting the number of inquests as a cost saving measure. Efforts were made to curtail the activity of the Coroner who was paid by the number of inquests performed (Granger, 1984).

The Coroner's Society of England and Wales was formed in 1846 in an organized attempt to pursue independence for the office. When the County Coroner's Act of 1860 was passed a degree of independence was created for the Coroner as payment was by salary, rather than by inquest. The independence was tempered as the Justice of the Peace continued to set the salary for the Coroner and had the ability to approve or disapprove of inquest expenses (Granger, 1984).

Significant change was not seen until the introduction of the English Coroner's Act in 1887 which has been described as "a watershed in the development of the office of the Coroner" (Granger, 1984) and the statutory basis for the law governing the Coroner in England, Wales and Canada today (Cain, 1988).

The Coroner's Act laid out that the primary function of the Coroner was no longer to "protect the financial interests of the Crown" (Granger, 1984), but to
investigate the circumstances and causes death in situations which would benefit the community in general. Deaths to be investigated were not limited to those involving violence or criminals, but included sudden or "unnatural" deaths where the cause was not clear, deaths that occurred in prisons, and any death from which the public might benefit from a public inquiry. Duties that had become unnecessary or inappropriate over time were removed from the jurisdiction of the Coroner. Some duties that were not connected with death were maintained such as holding inquests into treasure trove or acting in the place of the sheriff under certain circumstances (Granger, 1984).

The Coroner could attribute sudden and violent deaths to five causes: "1) by the visitation of God: 2) by misfortune: 3) by one’s own hand, as felo de se: 4) by the hand of another where the offender is not known: and 5) by the hand of another when he is known" as laid out by John Imprey in his 1835 edition of a manual for coroners (Marshall, 1980).

In 1888 the Local Government Act directed that coroners should be appointed and not elected, strengthening the independence of the Coroner from the control of the Justice of the Peace and contributing to the concept of the professional Coroner’s system (Granger, 1984). The office of the Coroner was enhanced even further with the passage in 1926 of the Coroners (Amendment) Act. The 1926 Act gave the Coroner the power to order an autopsy in cases where the death may be due to natural causes and to holding a post-mortem examination (the modern day inquiry) where it could be decided that an inquest was not necessary. Outlined in the Act was that the Coroner must adjourn an inquest if charges of murder, manslaughter or
infanticide had been laid. The inquest could not be re-commenced until the criminal proceedings had been dealt with (Granger, 1984).

The Coroner’s Rules of 1953 made clear that the role of the Coroner was to maintain a separate role from the criminal justice system. In 1971 the Brodrick Report abolished the Coroner’s duty to name the person responsible for the death and the power of the Coroner to remand the named person until trial (Granger, 1984).

The Coroner in Canada

The office of the Coroner was introduced to Canada as part of the British common law system and tradition. As a colony of Britain, Canada was subject to English Common law and statutory law (Marshall, 1980). The earliest reference to the Coroner in Canada occurred in 1785 in an Ordinance passed by the Lieutenant Governor in Council in Hamilton (Granger, 1984).

The functions of the Coroner in Canada appear to have paralleled those of their British counterparts during the eighteenth and nineteenth centuries (Granger, 1984). In Canada the Coroner concentrated on the medical causes of death and circumstances in which the death occurred and had less to do with the detection and prosecution of crime, although the early Canadian Coroner’s court was considered a court of "criminal record" (Marshall, 1980).

The constitutional issue of jurisdiction over the Coroner in Canada is a long standing debate. The British North America Act of 1871 placed criminal law under Federal jurisdiction. Statutory powers and duties of the Coroner to indict a person for unlawful homicide, to commit them to trial and to bind over material witnesses by
recognizance were assimilated into federal criminal law in 1869. The first Criminal Code of Canada in 1892 abolished the Coroner’s power to indict and commit persons for trial. The Coroner’s inquest, however, was still considered to play a role as a criminal investigation device and it can be argued that it still does as the findings of an inquiry or inquest may form the determination as to whether or not criminal charges are laid (Granger, 1984).

Marshall attributes the issue to the question to whether or not the institution is in the realm of criminal law, or whether it is "ancillary to the criminal process" and thus not necessarily under federal jurisdiction (Marshall, 1991). The issue continues to be addressed in court challenges to the Supreme Court of Canada with no final resolution to date.

Despite the question of jurisdiction each province has developed its own legislation to deal with sudden deaths. The systems used in Canada include the Medical Examiner system in use in Alberta, Manitoba and Nova Scotia. The Office of the Coroner is in use throughout the rest of the country, with the exception of Newfoundland which abolished the Office of the Coroner in 1875 and uses the courts to conduct inquests into sudden deaths (Granger, 1984).

The Medical Examiner system creates two parallel investigations into a death. The Medical Examiner is a physician who is charged with the task of determining the medical cause of death. The public inquiry is conducted by a second official who is legally qualified. An inquiry is usually conducted without a jury. The official conducting the inquiry is considered to be capable of determining what witnesses need to be called and what evidence should be heard. The Medical Examiners system
professionalises the investigation of the death while limiting the use of community members to determine why the death occurred.

The Coroner’s system has a Coroner who investigates the causes and circumstances of the death, determines if an inquiry or inquest will be held and conducts the inquest with a jury. Medical qualifications are not a requirement to be a Coroner, and in fact most Coroner’s are not medical practitioners. A Coroner is not required to have formal training or experience in law. Juries are formed of community members who are not required to have any professional or expert standing (Granger, 1984).

The Coroner in British Columbia

The office of the Coroner has existed in B.C. since Vancouver Island and the mainland united as a colony in 1866. Both areas were considered to have been acquired by settlement and thus subject to English common and statutory law as provided for under the English Law Act. The English Law Act stipulated that colonies acquired by settlement (versus conquest, treaty or cession) would use the English criminal and civil law as it existed on Nov. 19, 1858 as modified by subsequent provincial laws passed by the Legislative Assembly (Marshall, 1991).

B.C. enacted its first Coroners Act in 1879. The Act underwent amendments from 1881 to 1884, and was replaced by the Coroners Act of 1885. The Act of 1885 was further consolidated with other relevant statutes (such as An Act Respecting the Expenses of Coroner’s Inquests Held Within Municipalities of 1887) in 1888 (Granger, 1984).
Amendments to the consolidated Coroners Act of 1888 occurred in 1897, 1911, 1924 and 1936. The Act underwent "much more substantial amending" in 1943, "but still kept its nineteenth century underpinnings" (Granger, 1984). The Act was consolidated again in 1948 and this version was altered little until 1960 when it was revised. Further amendments were made in 1962, 1965, 1968, 1970, 1972, 1974, 1976, 1978. The Act was repealed in 1979 by the current Coroners Act which had been proclaimed, but not implemented in its entirety in 1975 (Granger, 1984).

The 1972 amendment rescinded the authority of municipalities over Coroners. The Provincial Government assumed the administrative and fiscal responsibility for all Coroners in the Province, bringing the Vancouver and New Westminster offices under the jurisdiction of the British Columbia Coroners Service (B.C.C.S.) (Cain, 1988)

The Coroners Act of 1975 created the position of Chief Coroner for the Province and broadened the powers of the office substantially from those of the pre-1979 Supervising Coroner for the province. A Supervising Coroner was able to act only in an advisory capacity towards the other Coroners in the Province where as the Chief Coroner was made responsible for

...administering the Coroners Act and its regulations, and for supervising, directing and controlling all coroners in the province in the performance of their duties. He is required to conduct programmes of instruction for coroners and to prepare, publish and distribute a code of ethics for the guidance of coroners. He bears responsibility for bringing the findings and recommendations of coroners and coroner’s juries to the attention of the appropriate persons, agencies and government ministries. Finally he must perform such other duties as may be assigned to him by the Attorney General or by under other statutes or regulations (Granger, 1984).
The creation of the Chief Coroner's position has created a system of checks and balances within the B.C. Coroners System to ensure that all investigations, inquiries and inquests are conducted according to the provisions of the Coroners Act and in accordance with the principles and guidelines of the B.C. Coroners Service. The Chief Coroner has the responsibility of disseminating recommendations from inquests to the appropriate individual, agency or government ministry which furthers the Coroners preventative and educational role in reducing deaths.

The Office of the Coroner is mandated to determine how an individual met their death and to use the information gathered to prevent further deaths. A Coroner is clearly empowered to investigate child abuse deaths and to make the findings and recommendations of the jury public and known to the affected individuals, agencies and government ministries in an effort to diminish the possibility that more children may die as a result of abuse or neglect.

The Coroner and Child Abuse

Historically the Coroner has played a significant role in the identification of child abuse. The early records of the Coroner in Britain (where the office originated) provide an account of how children have been abused and killed through the ages. Over time the Coroner became an important force in bringing child abuse and neglect to the attention of the medical community and the public.

The formation of the Office of the Coroner in England in Medieval times created a public office mandated with determining "why" death had occurred in all but natural circumstances. Inquests were entered in the Coroner's records and
provided a written account of child abuse dating back to Medieval times, long before the work of Kempe and his associates in identifying the battered child syndrome.

The Medieval Coroner’s files deal more with infanticide than with the death of older children. The early records do not record the ages of children who were not infants (under twelve months of age). Deaths of children past infancy may have been listed as adults, thus obscuring the record of the Coroner’s involvement in investigating the deaths of children as opposed to infants (Damme, 1978).

The early records reflect the ambivalent attitude in Medieval England towards infanticide with deaths of adults predominating in the records and with few deaths of infants and small children being listed. The Catholic Church had jurisdiction in the investigation of infanticides, while the Crown had authority to investigate the deaths of adults. Although the Church could investigate the circumstances of the child’s death, the person who had caused the death could not be sentenced to death by the Church, unlike a person who was found guilty of causing an adult’s death. Even when the death of a child or infant was viewed by the Church as intentional, or as the result of neglect, it was not considered to be a homicide, reflecting the status accorded to infants and children in a society that used infanticide as a probable means of birth control and population regulation. (Records show that many of the infants killed were illegitimate.) The person deemed to have caused the death was given a "public and humiliating penance" for the sin of having killed the child (Damme, 1978).

Records kept by the Church do not include all instances of infanticide as children were easily killed and disposed of without anyone having been aware of
their birth or short life. McLaughlin suggests that Medieval society was survival based where the infant or small child was the most expendable member of the family. No doubt the infant or small child was also the easiest to kill (McLaughlin, 1974).

Daly and Wilson note that the deaths of infants and children occurred within the family and thus there was no one to advocate for an investigation into the circumstances of the child’s death as the family endeavoured to keep the death secret. The community as a whole was not likely to draw attention to the death of the child as the Coroner would seize the object causing the death (or the value of the object) for the Crown. Despite the risk of the community being fined if the Coroner discovered an unreported death, the community retained financial resources by not reporting the death, leaving no one outside of the family to raise the issue of the child’s death (Daly and Wilson, 1988).

The Church recognized that children were killed by overlaying (presumed to occur when an adult took a child into bed with them and suffocated the child, accidentally, with their body) as early as the 11th. century. In an attempt to reduce the number of children killed by overlaying, the church decreed that any parent guilty of the act would endure a penance of three years. The first two years the parent could consume nothing but bread and water, in the second two years the parent was forbidden to partake of meat or wine (Kellum, 1974). That the suffocation could be non-accidental and occur other than by overlaying did not appear to have been considered by the Church in the 11th. century.

King Henry 1 ordered that the Crown assume responsibility for investigating the deaths of children if the perpetrator was someone other than the child’s parent.
Deaths caused by the child's parent continued to fall under the jurisdiction of the Church (Damme, 1978).

In the 12th. century scalding was recorded as a cause of the death of children in the Church and Coroner's rolls. The death was usually investigated by the church and assumed to be accidental with the parent given the same penance as for overlaying. The 13th. century saw the recognition of the mother being directly involved in the causing the child's death when Thomas of Chobham listed the refusal to nurse a child and "death by the mother's own hand" in his record of penance (Damme, 1978).

Despite the Church having jurisdiction over the investigation of infanticides some cases of the deaths of children are recorded in the Coroner's records as early as 1194 (Helfer and Kempe, 1987). The information listed in the Coroner's files rarely included the age of the child and gave little insight as to how the child had come to die (Damme, 1978). The Pleas of the Crown at York between 1218 and 1219 list the following deaths of children:

Maleta daughter of Walter of Mehley was drowned in a ditch. Walter her father found her. No one is suspected. Judgement, Misadventure.

Adam of Marr was found drowned. Emma his mother found him. No one is suspected. Judgement, Misadventure.

Hugh son of Norman in the same way was found drowned. No one is suspected. Judgement, Misadventure (Stenton, 1937).

Kellum (1974) speculates that as drowning was a common form of infanticide, and the children were most often "found" by their parents, that deaths of children by
drowning in Medieval times should be viewed as likely being homicides committed by the parents.

Two other deaths listed in the same Coroner’s rolls appear to have been deliberate deaths of children, although the information given is meagre.

A boy was found dead shut in a chest in the field of Bilbrough. Serlo of Bilbrough found him and has died. No one is suspected. Judgement, It is not known who he was.

A boy was found dead in an earthen pot in a pit. Amabel found him first, and the jurors say that Hervey Crappes and Agnes his wife are suspected and therefore let them be taken (Stenton, 1937).

The Coroner’s roll does not explain how Hervey and Agnes Crappes were related to the child, or why they were suspected of causing his death. The cause of death in both cases was not listed, other than the circumstances of where the body was found.


It happened at Stone on Wednesday next after the feast of St. Augustine in the thirty-seventh year of King Edward the Third [May 31, 1363] that John Marston found the dead body of a child called Joan, whose death was caused by the boiling water in a brass pot. His pledges are John Moisant and Robert Morti[mer]. The four neighbours are Henry, Robert Fernelough junior, William Goodale, and Henry Russ junior; and they are pledges for each other.

Four neighbouring townships, Stone, Stoke-Mandeville, Bishopston, and Dinton, present that on Friday next before Whit Sunday a certain pot full of boiling water stood on the hearth, one of its legs resting on a stone, and it fell from the stone and the boiling water fell upon Joan, Nicholas Ross’s daughter, who was a little over half a year old, and thus she came to her death. The pot was worth two shillings (Gross, 1881).
Coroner/Child Abuse

(The worth of the pot is the amount that must be paid to the Crown for the death and thus was recorded in the Coroner's rolls).

The adults accused of causing the child's death defended themselves by producing others who could pledge (swear) to their good behaviour and thus satisfy the court that they had not caused the death (Damme, 1978). Insanity as a defense in cases of mothers accused of infanticide was first recorded in the 12th. century. The victims were often not infants, but rather children over the age of one year. Mothers claimed to have been deranged, suicidal or sick with a high fever, and not aware of what they had done. Insanity as a defense appears to have been successful as a review of 2,933 homicides from 1300 to 1348 produced only one record of infanticide in the Coroner's rolls and jail records (Hannawalt, 1975). The lack of convictions appears to reflect the reluctance of the Church and secular court to convict a mother of killing an infant or even an older child (Damme, 1978).

Deaths of children in the 12th. century were attributed to misadventure and accidents, and rarely was a parent convicted of homicide. Offenders were found not guilty on the basis of the oath of the pledge, or a plea of insanity, with little attention being paid to the circumstances of the death (Stenton, 1937).

Drowning and scalding were the most frequently listed causes of death in the Church's records in the 12th. century, and continued to be frequent as the Coroner assumed the responsibility of investigating the deaths of children during the reign of King Henry the Eighth. Overlaying, the most frequent method of infanticide, was not listed in the Coroner's or Church's records. Damme speculates that this may have been a reflection of the difficulty in determining the cause of death and the intent to
kill, the church was left to deal with the issue of overlaying as a venial sin committed by the parent (Damme, 1978).

By the 15th century penalties for killing children had become more severe and often involved the public stigmatizing of the parent. Helmhoz notes the sentence passed on a mother convicted of killing her son in 1470.

The judge ordered that Joan should dress in penitential garb and "go before the procession in the parish church on Hythe on three Sundays with a wax candle of half a pound in her right hand and the knife with which she killed the boy, or a similar knife, in her left." She was also ordered to go twice around the markets of Cantebury, Faversham and Ashford in a similar fashion (Helmholz, 1974).

The sentence was intended to humiliate the mother and warn others against killing their children. The majority of deaths of children continued to be investigated by the Church (Damme, 1978).

The English Bills of Morality of 1519 and 1623 list children who were overlaid, starved, burned, scalded and drowned (Radbill, 1976). Court records from the middle and late sixteenth century from the Essex Sessions and Assize Records list almost thirty deaths of infants, and several of mature children that were brought to the attention of secular authorities and the Coroner. Of the infants, all but three were illegitimate, illustrating the stigma attached to children born out of wedlock and the degree of risk to the illegitimate child (Damme, 1978). The Coroner's rolls provides some details of the deaths.

A baby was born in Cludens Close in Copt Hall Park, Epping, and was thrown into the "mud or slud" of the ditch; not guilty, but John Stile did it. [John Stile is the John Doe, or Unknown of the era.]

An infant, born "without the help of any woman," was strangled in the house of John Perrye yeoman, her master, at Stanford-le-Hope, [a
woman] secretly gave birth at night after which she cut the baby’s throat and threw him into a nearby stream, weighted with stones; guilty.

A woman strangled her newly-born infant; another widow was present and abetted her. The mother was hanged, and the abettor acquitted (Emmison, 1970).

The methods used to kill children were similar to the most common methods used today; asphyxiation, drowning, strangulation and, included less common means such as cutting the child’s throat or striking the head against an object (Emmison, 1970).

Deaths of illegitimate children became so great in number that legislation was passed by James 1 in 1623 making the killing, or concealment of the body, of an illegitimate child equal to the death of an adult and punishable by the death penalty (Daly and Wilson, 1988). The law overturned the earlier assumption of the courts that the child had been stillborn, leaving the accused in the position of having to prove that the child had not been born alive, in essence the mother was assumed to be guilty and had to "prove" her innocence (Damme, 1978). The law applied to "lewd Women that have been delivered of Bastard Children" and did not apply in instances where the mother was married, but caused the death of the child (Daly and Wilson, 1988).

The number of mother’s found guilty of killing their children decreased greatly over the next two hundred years as juries became reluctant to convict the mother. "Insanity" became a common finding and little regard was paid to the (limited) available medical testimony (Daly and Wilson, 1988). The law remained in effect until 1828 when the crime of "concealment" was extended to legitimate births. Juries
remained reluctant to convict a mother of infanticide and concealment as the only indictment possible was for murder (Damme, 1978).

The medical test to determine if the birth was live or stillborn consisted of placing the infant's lungs in water. It was thought that the lungs of a stillborn would sink as were thought to contain no air, while those of a live birth would float from the breath taken by the child and retained in the lungs (Daly and Wilson, 1988). The test was recognized as being unreliable by the Coroners and the courts and was discontinued by the early 1800’s.

Five hundred and twenty-nine infants were listed in the Bills of Morality for 1629 to 1636 and 1694 to 1703 as "overlaid and starved." One London parish listed two hundred and seventeen deaths of infants, forty-six of whom had been overlaid. The Coroner conducted weekly inquests into the deaths of children who had been overlaid or suffocated while in bed with the parent(s), over half of the children were under a month old (Helfer and Kempe, 1987).

Coroner’s records continued to show the deaths of children at the hands of their parents. The records from 1788 to 1829 contained inquests of infants who had drowned in outhouses, wells, pits full of water, ponds, pans of water and cisterns, unlikely places for infants to be on their own (Helfer and Kempe, 1987).

The records gathered by the Coroner were used in several Select Committees (public commissions) in England in the 19th century. Evidence presented illustrated the abuse and neglect of children that was occurring at the time. The Coroner was called upon to give evidence at the Return of Inquests on Deaths by Poisons and
noted that of five hundred and forty deaths by poison in 1837 to 1838 nearly a quarter had been of children under five years of age. Children at the time were often given drugs from birth to quiet them and the death rate from overdoses was high (Daly and Wilson, 1988).

Evidence was heard from Coroners at the Select Committee on Protection of Infant Life in 1864. The evidence presented indicated that the prevalence of infanticide was greater than that recorded in murder convictions as juries were reluctant to find a mother guilty of homicide in the killing of her own child (Havard, 1960).

The Coroner from Manchester testified at the 1871 Select Committee on Protection of Infant Life with regards to the lack of regulations that the body had to be certified dead by a medical practitioner. Testimony was heard from the Coroner that violent deaths of children may be concealed to "a considerable extent" if the body was not examined by a doctor to assist in determining the cause of death (Havard, 1960).

Coroners were instrumental in bringing an end to the "burial clubs" that existed in England in the early half of the 19th. century. The clubs provided "insurance" to a parent against the life of the child. Coroner’s inquests revealed that some children had been enrolled in several clubs with the parents collecting from each club upon the child’s death. Poisoning, especially with arsenic, became a popular means of dispensing with heavily insured children (Daly and Wilson, 1988). The Coroners presented evidence that as many as two or three children in a family were dying while enrolled in burial clubs. The initial efforts to have the clubs ruled
illegal were not successful as the Justices of the Peace (Justices) interfered with the
Coroner's ability to hold inquests into the deaths.

Coroners testified at the Select Committee Of Friendly Societies (burial clubs)
in 1854 in an effort to demonstrate the risk the clubs posed to children, the testimony
had little effect. It was not until thirty-five years later when the Coroner had
established the right to hold inquests independent of the Justices and controls had
been imposed upon the clubs (limiting the insurance that could be placed on one
child and that deaths had to be certified by a doctor) that the concerns of the
Coroners were recognized. The Select Committee Of Friendly Societies in 1889 noted
that it was "convinced that allegations of culpable and even wilful neglect or violence
resulting in deaths of children are well founded" after hearing evidence from
Coroners (Havard, 1960).

The Daily Telegraph newspaper of London reported that 3, 901 inquests into
deaths of children under the age of two years were held in the five years from 1856
to 1860. The practice of infanticide in cases of unwanted children appeared to still be
in place as only two hundred and ninety-eight convictions of "wilful murder" were
returned by the juries (Daly and Wilson, 1988).

The Coroner advocated for an independent system with the right to hold an
inquest, and use medical testimony without seeking permission from the Justices of
the Peace in the 1800's. (The Justice of the Peace had been given control over the
funds spent by the Coroner in the conducting of inquests in Medieval times to ensure
that the Coroner remained honest and did not waste the Crown's money). By the
19th. century the two systems had become adversarial. Justices of the Peace refused
to release the funds the Coroner required to hold an inquest, or to pay for medical experts, in an effort to control the power of the Coroner (Havard, 1960).

Coroners challenged the right of the Justices to limit their power to conduct an inquest as they recognized the need for an independent system in the investigation of death. Coroners advocated for the right to hold inquests into cases of sudden and violent deaths, including the deaths of children. Application was made by a Coroner in 1847 to the High Court to challenge the refusal of the Justices to pay the cost of an inquest in a case involving an unattended seven year old girl who had been burnt to death. The Coroner presented evidence that seven inquests of a similar nature had been conducted that year and that "in each case varying degrees of neglect had been evident on the part of the parents (Havard, 1960).

The efforts of the Justices to control the number and nature of inquests lead to a resolution passed in 1851 in Middlesex, and adopted across England, that the Coroner would not be informed of sudden deaths, except for in certain instances. Police were informed that "the coroner should not be called or informed in cases of mere accidental death, such as death caused by falling from a house, or from scaffolding or a building, or infants overlaid in bed" (Havard, 1960). Reports of deaths decreased and in some counties inquests dropped by half. Inquests were not held in instances of overlaying despite the recognition by the Coroner that some cases of overlaying were in fact murder (Havard, 1960).

A court challenge was launched in 1857 when the Justices refused to allocate the fees for an inquest into the scalding death of a sixteen month old child. The
Coroners presented evidence at the Royal Commission on Costs of Prosecutions in 1859 and advocated that inquests be held in all cases of accidental and sudden death, including the deaths of children. The Coroners used the examples of children being poisoned and killed for the insurance from burial clubs as examples of why an independent Coroner's system with the ability to use medical experts was needed. The Royal Commission upheld the right of the Coroner to hold an inquest in cases of accidental and sudden death, but did not grant the Coroner the discretion to determine when an inquest would be held. The Select Committee of Coroners in 1860 was clear in its statement that "It is far better that inquests should be occasionally be held unnecessarily than the chances of detecting great crimes should be diminished" and advocated for inquests in case of sudden, violent or potentially criminal deaths (Havard, 1960).

Statutory recognition of the Coroner's independence and jurisdiction was given in the English Coroner's Act of 1887 and continues to this day.

Efforts had been made since the inception of the Coroner's system to avoid inquests. The Medieval inquest saw the cost of the object causing death being paid to the Crown and potentially represented a financial hardship to the family and/or community (Marshall, 1980). Attempts were made throughout the history of the Coroner's Office to circumvent the inquest by parties who had caused a death as the inquest could lead to a trial and a possible finding of guilt. The inquest was most often avoided by the body being concealed or disappearing. The first convictions for
attempting to avoid an inquest were laid in child abuse cases by Coroners (Havard, 1960).

In 1884 a Coroner in England announced that an inquest would be held into the suspicious death of a child. The body was burnt by the parents in the belief that the Coroner could not proceed with the inquest without the body or a medical examination of how the child had died. Charges were laid against the parents by the Coroner for destroying the body, and upheld by the courts, making the destruction of a body to prevent an inquest an offence for the first time (Havard, 1960). The offence continues in modern law, as seen in the B.C. Coroners Act, Section 12.

The law was initially only applied in cases where the party had been made aware of the Coroner's intent to hold an inquest. The first convictions in which the party had not been aware of the Coroner's intent to hold an inquest were also in the deaths of children. A midwife was convicted in 1910 for burying the body of an illegitimate child that was allegedly stillborn. The parents of a three month old child were convicted of "burying the body of a child who had died a violent death" as a means of avoiding an inquest in 1913 (Havard, 1960). Post-mortem examination showed that the child's skull had been fractured, but no conviction was obtained on the charge of murder as the cause and circumstances of the fracture could not be demonstrated.

Neglect was first ruled as grounds to hold a Coroner's inquest in a 1933 case in England. A three month old child was concealed in a "hedge bottom" to prevent an inquest being held. Post-mortem examination determined the cause of death to be bronchi-pneumonia. Witnesses were called to attest to the parent's lack of action in
the preceding weeks when the child had clearly been ill. The pathologist testified that the neglect had at least accelerated the death. The court ruled that a report must be made to the Coroner of "any death which they have reason to believe has been directly or indirectly caused by any sort of accident, violence or neglect..." (Harvard, 1960).

The Modern Coroner has close ties to the world of forensic pathology as the detection of the cause of death has become more sophisticated over time. The medical profession has historically played a strong role in the identification of child abuse and neglect (Helfer and Kempe, 1968). Hippocrates and Galen wrote of the treatment of children before the birth of Christ. Rhazes gathered the first medical information regarding children in a single monograph in the 10th. century and he "mentioned casually, that ruptures can occur when children cry or scream a great deal, and that it may be from being struck intentionally" (Radbill, 1987).

Zacchius (1661), Swammerdam (1667), Bonet (1679) and Schoepffer (1684) all produced works on children who had died as a result of abuse or neglect (Helfer and Kempe, 1968). Tardieu, a professor of legal medicine at the University of Paris published a study titled A Medico-legal Study of Cruelty and Brutal Treatment Inflicted on Children in 1860. The article detailed the autopsies he had conducted on thirty-two children who had died of alleged "accidents" (Masson, 1984). Tardieu identified all of the features of the "battered child syndrome" outlined by Kempe in 1962 (Silverman, P., 1978). The parents were identified as having caused the death of the child in twenty-one of the cases. Thirty-one deaths were due to physical abuse, and one to sexual abuse. Tardieu appears to have been well aware that his study
would likely not find a receptive audience in 19th. century Paris. He expressed frustration in the 1879 edition of the book that his work had not created any interest or anger towards the treatment of children.

This study, undertaken eighteen years ago, is the first to have been attempted on this subject, about which writers in the field of legal medicine have subsequently remained completely silent (Tardieu, 1879).

The six editions of his study printed after the initial publication included his findings on the sexual abuse of children, including sexual assaults that caused death. As with his initial work the subsequent editions received virtually no recognition at the time, or later in the medico-legal literature on infanticide that was a popular topic in 19th. century Europe (Masson, 1984).

The issue of child abuse did not become of interest to the medico-legal profession until the work of Helfer and Kempe was widely publicized in the 1960’s. Medical advances clearly influenced the medical findings that children suffer injuries, the X-ray enabled the detection of recent, healing and healed fractures and this lead to the early work of Caffey (1946) in identifying child abuse. The Coroner utilized the medical advances to understand how the human body was injured and killed. The autopsy, and in particular the forensic autopsy, allowed the body to speak of what had happened without the overlaying of social attitudes or constraints (Jaffe, 1991).

The files of the Coroner were recognized as a source of data on fatalities caused by child abuse and neglect in the 1960’s. Studies were done by Adelson (1961) to Greenland (1987) and contributed to the knowledge of child abuse by identifying which children were at risk, from whom and how the children were
killed. The files provided data on all aspects of fatal child abuse investigations from police reports to forensic findings and permitted the researchers to develop a more comprehensive view of child abuse and neglect.

The 1970's and 80's saw a large increase into the number of Coroner's inquests held into child abuse deaths in North America and England (Reder et al, 1993). The findings and recommendations arising from the inquests led to direct changes in the field of child welfare. The Helpline for Children in B.C. was created in 1978. Prior to that there was no clear process for reporting child welfare concerns after hours or on weekends. This gap was noted in an inquest into the death of a child fatally injured by abuse.

**British Columbia Coroner's Act and Coroners Service**

The authority by which the British Columbia Coroners Service's (B.C.C.S.) mandate is exercised is contained in the *Coroners Act* of 1975, as amended (Chapter 68, R.S.B.C., 1979).

"One or more coroners in and for the Province, or for any less extensive area that he thinks proper" may be appointed by the Lieutenant Governor in Council (Coroners Act, 1 (1). The B.C.C.S. is a branch of the Ministry of the Attorney General, but operates at "arms length" to ensure impartiality and independence (R.D. Valentine, Regional Coroner, personal communication, 1995). The Attorney General may authorize one Coroner to "direct the administration of the coroner's courts in a municipality" (Section 5). (The 1972 amendment to the Coroners Act of 1960 rescinded municipal responsibility for Coroners eliminating the Vancouver and New
Westminster municipal Coroners offices and bringing them under the direction of the B.C.C.S.) (Cain, 1988).

The Chief Coroner, Regional Coroners and full time Coroners in B.C. are hired on the basis of their investigative skills, legal or medical background, interpersonal and communication skills and for having an "inquisitive and inquiring mind" (R.D. Valentine, interview, 1995: Cain, 1988). Part time Coroners are hired if they possess an inquisitive and inquiring mind, have the time to perform the duties of the office, demonstrate communication skills and have the respect of the community they serve (Cain, 1988).

Under the Coroners Act provision is made for a judge to serve as a Coroner in designated circumstances. A Provincial Court judge may "perform any of the duties and exercise any of the powers of a coroner in the absence of a coroner or at the request of the Attorney General" (Section 8). The judge's authority is tempered in that the judge who has held an inquest may not subsequently " preside at the preliminary hearing or at the trial of a person who is charged with an offence arising out of the acts which may have caused the death" (Section 8 (2).

The Coroners court is one of fact finding and not a criminal court of record (Section 60, Coroners Act). Under Section 28 (2), "Purpose of inquest," the jury assembled for the inquest "shall not make any findings or legal responsibility or express any conclusion of law on any matter referred to in subsection (1). The five most important questions of common law that the Coroners court answers are

a.) Who was the deceased
b.) How did the deceased come to meet his or death.
c.) When the death occurred.
Where the death occurred.
By what means the death occurred (Marshall, 1980) (Coroners Act, Section 28 (1)).

The Policy and Procedures Manual of the B.C.C.S. states the goals of the Coroner as

1.) To clarify for the public record the facts of all unexpected and unnatural deaths.
2.) To prevent future loss of life in circumstances similar to those by which persons have come to their deaths unexpectedly or by unnatural causes (Coroners Service Policy and Procedures Manual, 1995).

The B.C.C.S. outlines the principles of the Coroners Services as

1.) The BCCS is a fact finding service not a fault finding service.
2.) The BCCS must be an independent service to the people of the community.
3.) The BCCS serves, first, the deceased and relatives and friends of the deceased; second, society as a whole; and third, government agencies and other organizations (Coroners Service Policy and Procedures Manual, 1995).

The Coroner has four main functions, investigative, judicial, preventative and administrative (Coroners Service Policy and Procedures Manual, 1995). At all times the Coroner is guided by the Coroners Act.

Provision for the appointment of a Chief Coroner for the province is contained in Section 3 and Regional Coroners are appointed under section 4. The Chief Coroner oversees the Coroners Service. Eight Regional Coroners administer the Coroners Act throughout the province and may have one or more full time or part time Coroners to assist them. Regional Coroners cover areas varying from a small geographic area with a large population, as in Vancouver, to a large area with a small population, such as Atlin in Northwestern B.C. (Cain, 1988). The number of Coroners under a Regional Coroner varies from offices with one full time Coroner, to the
Northern Region stretching from 150 Mile House to the Yukon border with one full time and twenty-seven part time Coroners (R.D. Valentine, personal communication, 1995).

The Coroners Act outlines when a death must be reported under Section 9 (1)

A person shall immediately notify a coroner or a peace office of the facts and circumstances relating to a death where he has reason to believe that a person has died
a.) as a result of violence, misadventure, negligence, misconduct, malpractice or suicide;
b.) by unfair means;
c.) during pregnancy or following pregnancy in circumstances that might reasonably be attributed to pregnancy;
d.) suddenly and unexpectedly;
e.) from disease, sickness or unknown cause, for which he was not treated by a medical practitioner;
f.) from any cause other than disease under circumstances that may require investigation; or
g.) in a correctional institution or prison (Coroners Act, 1979).

Notification of the Coroner is mandatory if a person dies while in a facility administered under the Community Care Facility Act, under the Mental Health Act, while in a public or private hospital or when detained by a peace officer (Section 9 (2) and (3), Coroners Act). The term peace officer is broad and includes all categories listed under the Criminal Code, including a police officer, Sheriff, Justice of the Peace, guard or employee in a prison, conservation officer, customs officer, fisheries officer, pilot in command of an aircraft while in flight, officers and enlisted personnel of the Canadian Armed Forces, bailiff, or others employed for the "preservation and maintenance of public peace" (Bethell, 1988).

Reporting the death of a child in the care of the M.S.S. to the Coroner is not mandatory in B.C. as it is in some jurisdictions. The Fatality Inquiries Act of Alberta
(Section 13) states that "The Director of Child Welfare shall immediately notify a medical examiner of the death of any child in his custody." In B.C. it is assumed that the death would be dealt with if it fit the criteria set out in Section 9 for deaths that must be reported. M.S.S. policy requires that the police be notified of the death of a child in care, or while an investigation was being conducted, the police in turn may then notify the Coroner.

In Nova Scotia the Coroner must report any incidence of child abuse deaths to the Provincial Child Abuse Register (Marshall, 1980). B.C. no longer has a child abuse register and the Coroners Act makes no mention of the M.S.S. having to be notified of a child’s death if the death was attributable to abuse and/or neglect.

In instances where an inquest or inquiry is not required the Coroner is required to transmit a signed statement to the Chief Coroner setting forth the results of the investigation and grounds for deciding that an inquest or inquiry is not necessary. The Coroner is required to register the death with vital statistics and to keep records indicating which cases were dealt with by inquiry, including the identity of the deceased, how, when and where the person died and details of relevant examinations of the body. Upon request the Coroner’s report from the inquiry may be released to the spouse, parents, children, brothers, sisters and personal representatives of the deceased (Section 18).

The Coroner has the power to conduct an inquiry under Section 21 if the Coroner is satisfied that an inquest is not necessary. An inquiry report must be forwarded to the Chief Coroner by the Coroner to ensure that an inquiry is sufficient to answer the questions arising from the death. Should the Coroner become aware of
information during an inquiry that necessitates the summoning of a jury, a jury may be summoned (Section 22).

An inquiry report and the inquest report hold the same weight, the difference being that the inquiry report is prepared by the Coroner alone, while the inquest report is prepared after a public hearing process involving fact finding by a jury under the guidance of a Coroner (Cain, Continuing Legal Education, 1988).

Inquest

The inquest is a public hearing process to determine the circumstances of death. An inquest is not a trial and there is no accused (Marshall, 1991). The purpose of the inquest is outlined in Section 28 (1) "Where an inquest is held, it shall inquire into and determine who the deceased was and how, when, where and by what means he died." The fact finding element of the inquest is outlined in subsection 2 "The jury shall not make any findings of legal responsibility or express any conclusion of law on any matter referred to in subsection(1)." A jury's findings will not be accepted if they contravene subsection 2 (Section 28 (4) and a jury that does not deliver "a proper finding" is dismissed (Section 28 (5). Recommendations may be made by a jury based upon the evidence heard at the inquest (subsection 3), but there is no authority within the Coroners Act to order the changes recommended. Nevertheless the recommendations must be communicated by the Chief Coroner to the relevant agency, persons and Ministries (Section 3). Responsibility to implement the recommendations or not rests those who receive the recommendations.
An inquest is to be conducted in public, unless the Coroner determines that national security "might be endangered" or where a person has been charged under the Criminal Code with an indictable offence and relevant evidence may be given with respect to that person's conduct (Section 29 (a) and (b). The Coroners Act stipulates that the Crown Counsel will be notified of the time and place of an inquest and may act as counsel to the Coroner (Section 27 (1). The Attorney General may be represented by counsel and is a "person with standing" at the inquest (Section 27 (2).

Section 19 gives the Coroner the power to issue a warrant for an inquest. An inquest must be held if the death occurred while the person was detained by a peace officer or in custody in a correctional institution, lockup, prison or in the custody of a peace officer (Section 9 and 10). "Detained" in Section 10 is interpreted to mean a person under arrest, a person not under arrest but not able to go anywhere, a person who is being "interrogated" and a person who is in the process of being arrested or was arrested (Bethell, 1988).

An inquest can not be held (and if commenced must be withdrawn or stayed) in situations where a charge has been laid of "murder, manslaughter or any criminal offence arising out of the facts which may have caused the death" under Section 23 (1). The Attorney General "may direct" that an inquest be held, or recommenced if the criminal charges are withdrawn or stayed under Section 23 (2).

The Attorney General also has the authority to order an inquest to be held (Section 24 (2), or for a second inquest into the same death to be conducted if concerns have arisen from the manner in which the initial inquest was conducted (Section 24 (2) (b).
An inquest can be held without a body in the event that the body has been destroyed, cannot be recovered, or has been removed from the Province (Section 20).

The Coroner makes the decision on whether or not to hold an inquest using the following criteria; the inquest is legally required by the Coroners Act; there is public and/or family concern with regards to how the death occurred; an inquest will serve as a vehicle to focus public attention on the circumstances of the death; and the Coroner is of the belief that further evidence will be forthcoming by witnesses having to testify under oath (Cain, 1988). The Coroner’s Act does not set out criteria limiting the Coroner’s decision as to whether or not an inquest should be held, leaving the Coroner with broad discretionary powers (Paterson, 1988).

The Chief Coroner has the authority to "direct" a Coroner to issue a warrant for possession of a body, to conduct an investigation or hold an inquest (Section 25) and thus ensure a safeguard is in place to determine if an inquest should be held.

Order is preserved at an inquest under Section 51. The Coroner is afforded the same "power and authority" as a judge sitting in Supreme Court. A Coroner has the authority to make orders or give the directions at an inquest that the Coroner (Section 51(2) " considers necessary to maintain order and to prevent abuse of the inquest process." A peace officer can enforce the direction or order made by the Coroner under section 51(3).

The Coroner can order an adjournment "to permit an adequate hearing" (Section 50). The Coroners Act does not speak to the length of an adjournment.

The early laws on the Coroner in Britain are reflected in the current statute. Medieval Coroners law forbid the moving of, or interference with a body until the
Coroner gave permission. The intent of the law was to ensure that any monies owing to the King due to the manner of death would be forthcoming and not circumvented by altering the apparent cause of death (Marshall, 1980). Under the current Coroners Act no one may "interfere with or alter the body or its condition in any way until the Coroner so directs" (Section 12). The intent of the current act is to maintain evidence and to ensure that the circumstances of death are as they appear to be. A charge of "obstruction of coroner" can be laid against any one who knowingly hinders, obstructs, interferes, attempts to interfere, provides false information, refuses or neglects to provide information to the Coroner or someone authorized by the Coroner in the course of an investigation (Section 53).

**Investigative Powers**

"The Coroner is the only person legislated to investigate deaths" (Cain, 1988). While police have a role in investigating deaths that fall under the Criminal Code of Canada, if it is established that the death is not a criminal matter the police act as agents for the Coroner.

To assist in the investigation the Coroner may issue a warrant for possession of the body (Section 15), prevent the shipment of a body outside of B.C. (Section 14), or guard "wreckage" (motor vehicle, boat, plane, building, bridge, structure, embankment, or apparatus) where a death has occurred (Section 13). A peace officer is able to assist the Coroner in these functions.

The investigative powers of the Coroner are outlined in Section 16. A Coroner, or medical practitioner or a peace officer authorized by a coroner, may "view or take
possession of any dead body, or both" and enter and inspect "any place" where the Coroner has "reasonable grounds for believing" the body is, or was removed from.

Under Section 16 (2) the Coroner may "inspect any place" the deceased was "within a reasonable" time of death, "inspect information in any records" (emphasis added) relating to the deceased or his circumstances" and "seize anything" (emphasis added) that the Coroner has reasonable grounds to believe is material to the investigation."

The Coroner has the authority to issue a warrant for a post mortem examination of the body. An examination can occur "with or without dissection" and may include analysis of body fluids, stomach and intestinal contents, toxicology tests, serology, blood typing, immunology, DNA testing and any other "examination or analysis" the Coroner considers to be warranted to determine the cause of death (Section 26: Ferris, 1988). The Coroner can order that an autopsy or other tests be conducted despite the "objections" of the deceased or the surviving family (Section 52). While the Coroner attempts to be sensitive to the needs of the surviving family, the mandate to determine how the person died is the primary focus in determining if post mortem procedures will be conducted.

Section 52 was used by the Coroner in cases 89/01 and 89/02 reported in the present study. The parents objected to post mortem tests being done on their children after the children were killed in a house fire the mother was suspected of setting. Religious beliefs of the parents forbade any interference with the body after death. The Coroner ordered an autopsy on the male child (89/01) who died first, but honoured the beliefs of the family as much as was possible by determining the cause of death
for the female child (89/02) who died three days after her brother by the use of blood
tests to determine the gas levels in her blood. As the children had been in the fire
together the Coroner was able to extrapolate the gas levels to the inhalation of smoke
and gases in the fire.

A Coroner can be disqualified from conducting an investigation, inquiry or
inquest (Section 17). Should the Coroner have attended the deceased as a medical
practitioner within thirty days "immediately before the death"; performed a post
mortem examination of the body; is the owner, operator, shareholder or employee of
any company that has been involved in the death; he or she is disqualified as the
Coroner with regards to that particular death. Section 17 serves to ensure the
neutrality of the Coroner.

The jury has been a component of the inquest since the inception of the office
of the Coroner (Granger, 1984). The Coroners Act stipulates that an inquest will be
held with a jury (Section 30 (1) and it is intended that the jury will be impartial and
unbiased.

A jury is no longer comprised of all males over the age of twelve from the four
surrounding villages, but of "five persons" (Section 30 (2). The jury is no longer
obliged to conduct the inquest in the presence of the body (Marshall, 1980), but is
obliged to view the body if directed to do so by the Coroner (Section 34). The
Coroner, however, is required to view the body at the scene of the death or at the
morgue (Cain, 1988).

Under Section 31 a person may be disqualified from sitting on a Coroner’s
jury if there are concerns with regards to their ability to return a verdict in
accordance with the evidence (Section 31 (2). An officer, employee or inmate of an institution as set out in Section 9 where a person has died is excluded from serving on the jury inquiring into the death (Section 31 (3). Any person unable to read, speak or understand the language the inquest is to be conducted in is likewise disqualified (Section 31 (4). Section 3 of the Jury Act applies to jurors in a Coroners inquest and can be used by counsel for a party with standing at the inquest to disqualify a potential juror (O'Connor and Mitchell, 1988).

Jurors are sworn by the Coroner under Section 33 and take an oath to "diligently inquire concerning the death of a person on whose body the inquest is about to be held and to give a true verdict according to the evidence." The swearing of the jury reaffirms that the inquest first serves the deceased to determine how the person died. Where the death has occurred in the course of the employment of the deceased, or if the deceased falls under the jurisdiction of the Workers Compensation Act "reasonable efforts" are to be made to have persons familiar with the type of work the deceased was engaged in on the jury, and they may comprise the whole jury (Section 30 (6).

Members of the jury are able to ask "relevant questions" of each witness under Section 36. The Jury and Coroner are "invited to and actively participate in the questioning" of witnesses at the inquest (O'Connor and Mitchell, 1988). The jury hears the evidence and bases their findings and recommendations on the facts presented. This differs from the original function of the jury which was to provide evidence as to who the deceased was and how they had met their death (Granger, 1984).
Communication by members of the public with the jury during deliberations is forbidden (Section 45 (1) and a jury may be discharged if the Coroner is of the opinion that the communication with the jury "might lead to a miscarriage of justice" (Section 45 (3).

Early Coroner's juries decided on a verdict in secret as the decision of the jury was originally meant to replace the decision of God "who decided the outcome of the ordeal and presumably the battle and compurgation" (vindication) (Marshall, 1980). A modern jury meets alone to decide the evidence in a neutral setting free from the influence of others.

Recommendations may be made by a jury "in respect of any matter arising out of the inquest" (Section 28 (3). The Coroners Act does not specify who may put forth recommendations to the jury for consideration. Some Coroners leave the recommendations to the jury to make, while other Coroners suggest recommendations. Counsel for a party with standing may imply recommendations they think should be made by the skilled questioning of witnesses (O'Connor and Mitchell, 1988).

Recommendations made by the jury are not enforceable by the Coroner. The Chief Coroner distributes the recommendations in writing to the appropriate individuals, agencies or government ministries. The decision to implement the recommendations or not rests with the individual, agency or government ministry (Cain, 1988). The recommendations are primarily regarded as educational and are intended to prevent further deaths. Despite the Chief Coroner having no authority to enforce the recommendations a large number are in fact implemented. The decision
to implement the recommendations may be influenced by the ability of the Coroner to make the findings of an inquest public thus ensuring that the public is aware of both the concerns and the recommendations of the jury to address the concerns.

A jury gives their verdict in writing under Section 46 (1). The verdict does not have to be unanimous, but must be agreed to by a minimum of three of the jurors (Section 47 (2). Should a verdict not be reached the Attorney General may order the Coroner to hold a second inquest with a new jury, "or take any action the Attorney General considers proper (Section 47 (4).

The findings of the jury, and recommendations if made, are generally reviewed by the Coroner to ensure that they fall within the guidelines of Section 28.

Anyone failing to respond to a summons to appear as a juror for a Coroners jury may be arrested and fined up to one hundred dollars (Section 32).

**Witnesses**

The Coroners Act addresses the issue of witnesses in several sections. A Coroner is able to issue a summons to a witness under Section 38 (1). Witnesses can be compelled to attend the inquest and failure to do so may result in the witness being charged under the *Offence Act*. The summons is limited in that it is not legally enforceable outside of B.C. (Paterson, 1988), thus an individual can avoid appearing at an inquest by leaving the Province.

The Coroners Act recognizes that although the Coroners court is not a court of criminal record evidence can be presented at the inquest that is used to determine whether or not criminal charges will be laid. Protection for witnesses is addressed in
Section 40 of the Coroners Act which renders inadmissible in civil and criminal court trials any statements made by witnesses at an inquest. Coroner and Crown Counsel are to "ensure that the witness is informed of his rights under Section 5 of the Canada Evidence Act." The Canada Evidence Act "provides some protection for witnesses against self-incrimination" (Israels, 1988).

The protection of the Canada Evidence Act has been re-enforced by court decisions which have held that where a witness has been charged "with a criminal offence relating to the death under investigation, the witness is not a compellable witness at the inquiry" (Batary v. A.G. Saskatchewan) (Israels, 1988).

The courts have likewise ruled that if a witness is "uncharged" (and even if the witness is likely to be charged in the future) the witness is compellable at the inquest due to the ruling in R. v McDonald and Attorney General for British Columbia. The court ruled that the decision arising from Batary applied only to a witness charged with a criminal offence arising from the death being addressed at the inquest (Israels, 1988).

Witnesses are entitled to counsel under Section 41, but the role is "restricted UNLESS otherwise allowed by the coroner" (Bethell, 1988). Counsel for the witness will attempt to avoid a finding by the jury (ie. of homicide) that may imply criminal responsibility on the part of the witness (Israel, 1988).

The protection of a witness has been demonstrated to be an important component of preserving the rights of an individual to not incriminate themselves. In case number 86/09 reported in the present study the mother utilized the protection offered by the Canada Evidence Act during the inquest into the drowning of her
malnourished daughter after retaining counsel part way through the inquest. Despite the mother being a suspect, no criminal charges have been laid to date.

A Coroner has the authority to summon a medical practitioner to give evidence where the medical practitioner attended during the deceased's "last illness, or at his death" (Section 39 (1) (a) or was "in actual practice in or near the place where the death happened (Section 39 (1) (b). The medical practitioner can be summoned if he or she conducted or assisted in the post mortem examination of the deceased (Section 39 (2).

A Coroner has the ability to "retain the services of" expert witnesses under section 58 (2) to assist "with all or any part of any investigation, inquiry, or inquest." The authority to retain expert witnesses allows the Coroner to utilize the services of experts in the medical field (ie. forensic pathologists, toxicologist, dentists and psychiatrists), in areas as diverse as botany, entomology, archeology, salvage divers, rescue teams, fire scene investigators, model builders and any other field applicable to the investigation, inquiry or inquest. The ability to utilize experts ensures that the Coroner is unrestricted in the investigation of the death (Cain, 1988).

The Coroner's inquest differs from a criminal proceeding in that the right to examine witnesses rests not only with the Coroner (Section 35), but also with "A person whose interests may be effected by evidence likely to be adduced at an inquest." (Section 37 (1). Thus any person granted standing at the inquest is able to summon compellable witnesses (Section 37 (1) (d), to call evidence (37 (1) (b) and examine, cross examine and re-examine witnesses (37 (1) (c). Section 37 ensures that anyone who has an interest in the outcome of the inquest has an opportunity to
ensure that they have been represented in the process and have been able to
demonstrate their position through the calling of evidence and examination of
witnesses.

The test for being given standing rests in case law and has been summarized
as anyone whose "rights may be affected; recommendations might be made affecting
them; their interests are greater than that of the public or any other agency" (Bethell,
1988). Standing has been obtained by family members, Provincial Ministries (ie. the
M.S.S. in cases of child abuse where the M.S.S. was, or should have been, involved),
Native Bands and agencies.

The Coroners Act provides for the employer and trade union to have standing
when a worker has died in the course of employment (Section (37 (2).

Evidence is admitted under Section 42. The inquest is not bound by the rules
of evidence used in criminal proceedings, although privilege remains protected
(O'Connor and Mitchell, 1988). Evidence may be admitted that is "relevant to the
purposes of the inquest" (Section 42 (1). The burden of proof becomes one of
meeting "standards of proof as are commonly relied on by reasonably prudent
persons in the conduct of their own affairs" (Bethell, 1988). The more stringent
measure of burden of proof used in the Criminal Code is not applied to evidence in a
Coroner's inquest.

The evidence entered at the inquest may lead to criminal charges being laid or
a civil suit being filed as evidence is heard that may not have been known
beforehand, reinforcing the need for witnesses to be aware of the protection offered
to them under Section 40.
Section 43 requires that there be a written record of the evidence taken at an inquest. Under Section 44 "a copy of a document or other thing may be admitted as evidence at any inquest" provided that the Coroner is satisfied that it is authentic. Copied evidence observed on the Coroner’s files in the present study include professional reports, footage filmed by a news team and agency reports.

The Coroners Act outlines the penalties for the contravention of certain sections of the Act in an effort to ensure compliance in the investigation to determine why the deceased died. Contravention of Sections 9, 10, 11, 12, 14 or 53 is considered an offence. The person convicted is liable to a fine of not more than one thousand dollars, up to six months in prison, or both. A conviction can be appealed to the B.C. Supreme Court under Section 56.

**Protection of the Coroner**

In caring out the duties and functions of the office it is possible that a Coroner may be vulnerable to criticism for the actions taken to complete an investigation. Protection is afforded to the Coroner under Section 57 in that the Coroner is "not liable for damages caused by anything done or not done by him in the performance of his duties or in respect of a matter in which he lacked or exceeded his jurisdiction unless it is proved that he acted in bad faith or without reasonable and probable cause." The broad powers of the office of the Coroner are thus balanced with the protection of the individual Coroner, or agent, who is acting under the powers.

The powers of the Coroner are further balanced by the authority of the Lieutenant Governor in Council to make regulations under the Coroners Act. The
"generality" of the Act can not be restricted, but regulations can be made with regards to the powers and duties of the Chief Coroner, fees for service for Coroners, fees for services provided under the Coroners Act, and grounds for the disqualification of jurors due to interest or bias on the part of the juror and the addition of rules for the procedures followed at the inquest (Section 59).

The Coroner is charged with the task of protecting the living through the examination of death to prevent further deaths under the Coroners Act. Cain writes that the power of the system is, and should continue to be, directed towards "certain classes of persons who, by reason of age, chronic illness, mental retardation, mental disease or legal confinement, are largely dependent for their health and safety upon the proper actions of those into whose care or custody they have been committed." (Cain, 1988).

Children are among the most dependant members of our society. They are dependent on their parents or caregivers to meet their day to day needs and to afford them protection. In instances where the parent or caregiver not only does not protect, but abuses, or neglects the child the M.S.S. has the mandate to protect the (living) child. In situations where the child has been killed by the actions, or lack of action, of the parent, caregiver or any other person the Coroner has the mandate to determine how the child died. A Coroner has the authority to make recommendations that may prevent the loss of the lives of other children. The ability of the Coroner to educate not only those who were involved in the child's life, but also the community in general, of the risks, abuse and neglect the child faced has the potential to bring the issue of child abuse and neglect to the attention of the general public. The reality
of child abuse and neglect deaths must be known by the public to ensure the support and services to prevent further deaths.

**Child Protection Legislation and Policy Concerning the Fatalities of Children**

The assumption that children have the right to protection from the actions (and lack of actions) of their parents and caregivers is an historically recent phenomenon. "Children in our own, and perhaps in every society past and present, have always been subjected to a wide range of physical and non-physical abuse and exploitation by parents, other caretakers, and, not infrequently, by society as a whole" (Gil, 1968).

The protection of children from abuse and neglect is provided in B.C. by the Family and Child Service Act (F. and C. S. Act). The F. and C. S. Act was proclaimed in 1981 and provides the legislative authority for the Ministry of Social Services (M.S.S.) to intervene in situations where there is reason to believe that children have been abused and/or neglected. The F. and C. S. Act replaced the Protection of Children Act which had been implemented in 1901 as the first piece of child welfare legislation in B.C.

One principle guides the F. and C. S. Act, "In the administration and interpretations of this Act the safety and well being of a child shall be the paramount considerations" (Section 2). The legislation does not define what is meant by the safety and well being of the child. The Act provides five clauses under which a child may be found in need of protection

(a) abused or neglected so that his safety or well being is endangered,
(b) abandoned,
(c) deprived of necessary care through the death, absence or disability of his parent,
(d) deprived of necessary medical attention, or
(e) absent from home in circumstances that endanger his safety or well being (Section 1).

The Act does not provide further definitions of the five clauses leaving the immediate decision up to the social worker in the field and the ultimate decision of whether or not the child is in need of protection (or was at the time of the apprehension) up to the courts and case law.

Social workers for the M.S.S. may have to deal with the death of a child at several different points in time. A child may die while the incident in which the injuries were inflicted are being investigated under the F. and C. S. Act. Or the child may have already died and the social worker is charged with the task of assessing the risk to other children in the home. When a child dies of suspected abuse or neglect the police are notified of the death and lead the criminal investigation.

Social workers, however, need to interview the non-offending parent and other children in the home to assess the risk to the other children under the F. and C. S. Act investigation that may occur parallel to the police investigation. Information is often provided by the police to the social worker on the results of the criminal investigation. The mandate of the social worker is to ensure that other children who may be in contact with the perpetrator are not at risk and if they are to take appropriate action.

Social workers in some situations may assist with the actual criminal investigation by assisting the police in interviews of the non-offending parent, other adults or children in the home, and in gathering information from outside sources (ie.
hospitals, doctors, school). The role the social worker plays in the actual criminal investigation is directed by the police. Ideally there is a mutual sharing of information between the police and the social worker to ensure that all information is known to both parties as the parallel police and child welfare investigations are conducted.

Police may require information the social worker has with regards to the family to place the death in context. A death in a family with a history of abusing or neglecting their children would raise concerns that may not occur if a family has no history or record of child welfare concerns. Information provided by the M.S.S. may assist the police in assessing the likelihood of the death having occurred in the manner described by the family. Social workers must be aware of the outcome of the police interviews if they are to ensure that the other children in the home are safe. If social workers are not told of the death they can not assess the risk. Should the social worker only receive partial information from the police they may inadvertently leave the child at risk. The reality in the field is that the police may not notify the M.S.S. of the death of a child as they are focused on conducting a potentially criminal investigation. In these situations the risk to other children in the home will not be assessed.

Social workers may deal with a child in care who was the victim of serious abuse at an earlier age. The child may later die of the injuries, such as children who die of seizures from previous brain injuries. As the child is in care the circumstances of the injury are usually known, have been investigated by the police and M.S.S. and the results are recorded by both. The child’s doctor is usually aware of the previous injury, especially if the child had been permanently damaged by the injury and was
receiving ongoing medical treatment. Deaths of such children are usually anticipated by the doctor and the medical reason is clear. Despite this the police are notified of the death and may be involved in investigating the circumstances. The death of the child within twelve months of the date of the injury may result in the offender being charged with causing the death. Should the death occur more than twelve months after the initial injury the offender can not by law be charged with causing the child's death.

A child in the care of the M.S.S. may die while in a foster home or child care resource. The police are notified and the role of the social worker is to assist in the determination of prior risk to the child from the caregivers. The social worker must also determine if other children in the foster home or resource are at risk. An investigation into the death of a child in a resource is similar to the investigation into the death of a child by a family member, in that those who had contact with the child must be eliminated as having caused the death.

A child may die during the first six months of an adoption placement, referred to as adoption probation. Police are notified and the social worker must assess whether the death was caused in any way by the adoptive family. The risk to other children in the home must also be assessed.

Children die while in the care of the M.S.S. from previous injuries, natural causes, accidental causes, and unfortunately some times from abuse or neglect by the caregiver. M.S.S. policy endeavours to ensure that the police are notified of the death and that the cause of death is determined.
The F. and C. S. Act does not provide direction in the case of a child who dies of abuse or neglect. As the Act reads that a report must be made on a child who is "in need of protection" (Section 1), the deceased child can be argued to be past the protection offered by the state. Agencies or individuals (hospitals, medical personnel, emergency crews) dealing with cases involving deceased children tend to notify the police immediately and often do not report the death to the M.S.S. The police in turn notify the Coroner. M.S.S. may be contacted during the investigative process by the police if there are other children in the home and if they are considered to be at risk by the investigating officer. M.S.S. may be contacted if information is sought from the files the M.S.S. may have on the child or family. As the notification of the M.S.S. is not clearly mandated by the F. and C. S. Act situations have occurred where the M.S.S. was not aware that a death had occurred and that other children in the home may have been, or continue to be, at risk.

When legislation is silent on a matter of practice, social workers turn to policy for direction. Policy concerning services to children and families is contained in Volume 2 of the M.S.S. policy manual. Volume 2 directs the social worker and district supervisor on how to proceed when a child dies and differentiates between the death of a child not in care (Section 6.5.3), the death of a child in a foster home or child care resource (Section 6.5.6), the death of a child during the six month adoption probation period (Section 5.2.13) and when the death occurs after the adoption order has been granted (Section 5.2.14).

The social worker must notify the district supervisor in each case. Police and the area manager are notified of the death by the district supervisor. Policy directs the
area manager to report the case to the regional director, the Office of the Superintendent of Child Welfare and the Assistant Deputy Minister of Field Operations.

M.S.S. has a specialized unit to review cases where children have died and the M.S.S. has had, or should have had, contact. The Audit and Review Division is mandated to review the field practice when a death occurs and to determine if the line staff were in any way at fault or negligent in the case. The Audit and Review Division is notified of the death by the Superintendent of Child Welfare and may conduct their own investigation into the death. The investigation is an internal review and the results are generally not shared with the public.

When the deceased child was not in the care of the M.S.S. at the time of death the social worker is instructed by policy to prepare a report within five working days giving details of the child’s death. The social worker is to detail the immediate findings of the investigation conducted by the social worker and police, including the explanation given by the parents or caregivers for the child’s death. A report must include "The names and ages of other children living in the home where the child who died was living and if these children are at risk" (Section 6.5.3). Policy is clear that if it is determined that the child’s death was due to abuse or neglect and there are other children in the home an investigation "must be commenced immediately to determine if these children may be in need of protection" (Section 6.5.6).

The social worker’s report must include whether an autopsy has, or will be, performed (Section 6.5.4). Policy makes no mention of notifying the Coroner of the death or providing the Coroner with a copy of the M.S.S. report. It appears to be
assumed in policy that the social worker will know to contact the Coroner for a copy of the autopsy report.

Should the death occur in a foster home or a child care resource, policy directs the district supervisor to "immediately assign the review and investigation of the foster home or child care resource to a social worker who is not responsible for the subject child’s care or for the foster home or child care resource under review" (Section 6.5.6). The investigating social worker is to determine if there are any other children at risk, or potentially at risk, in the home. Policy makes no mention of the notification of the Coroner, despite the fact that the facility the child died in may be governed by the Community Care Facility Act and thus the death would fall under the jurisdiction of the Coroner.

In instances where a child dies while on adoption probation or after the completion of the adoption, the same process of notification within the M.S.S. is to be followed. Policy on deaths while on adoption probation is the only section to mention the Coroner. "If an autopsy is performed or if there is a Coroner’s report, a copy of the report is to be requested and forwarded to the Area Manager who will, in turn, forward the report to the Superintendent" (Section 5.2.14). Policy does not indicate that the social worker is to notify the Coroner of the child’s death.

When a death occurs on adoption probation, or after the completion of the adoption, the natural parent(s) of the child are to also be notified of the death (Section 5.2.14).

The F. and C. S. Act does not mandate that the Coroner must be notified of the death of a child when the M.S.S. is either involved in conducting an
investigation, has the child in care by agreement or by apprehension, the child is on adoption probation or the adoption has been completed. The Ministry’s policy and practice is to notify the police of the death and to cooperate during the investigation of the death. Police in turn notify the Coroner and the Coroner may or may not become involved depending on the circumstances of the case and the information presented. Should the investigating officer and social worker not recognize the death as being due to abuse and/or neglect and attribute it to an accidental or natural death, the Coroner may not be alerted to the death possibly being due to child abuse and/or neglect.

The Inter-Ministry Child Abuse Handbook (1988) does not directly address fatal child abuse. Direction is given, however on the protocol in the investigation of criminal matters in child protection cases. It appears to be assumed that a social worker would know to deal with the death of a child in the same matter as any other protection investigation which may involve the police. The Handbook makes no mention of the Coroner.

In August of 1995 the Child, Family and Community Services Act (C.F.C.S. Act) was proclaimed and implementation is set for January 29, 1996. The legislation will replace the current Family and Child Services Act. The C.F.C.S. Act provides for children to be removed from their parent’s care on more grounds than are available under the F. and C.S. Act. Issues of anticipated abuse and neglect and the threat of harm to a child from a person who does not live in the home are addressed in the new legislation. The legislation has been written to permit more community
involvement in assisting families and children, and offers more solutions in dealing with abuse and neglect issues than the F. and C.S. Act.

As with the F. and C.S. Act, there is no procedure within the new Act to require the reporting of deaths to the Coroner. Policy for the new Act is currently being written. If notification to the Coroner is not addressed, the same issues will arise as were demonstrated in relation to the F. and C.S. Act. The Coroner may not be sufficiently aware of the implications of abuse and neglect in the death, and past child welfare concerns may not be known to the Coroner. The lack of information provided to the Coroner may affect the findings as to why the child died. Child abuse and neglect deaths may not be identified and the reported deaths will not reflect the reality and frequency of deaths.

The B.C. Coroners Act and Child Abuse/Neglect Deaths

The Coroners Act does not address the notification of the Coroner if a child dies while an investigation is being conducted by the M.S.S.; if the deceased child is in care of the M.S.S.; or had previously been placed for adoption. The Coroners Act in B.C. is silent on the issue of child abuse and neglect deaths as is the F. and C. S. Act.

Legislation in Alberta partially addresses the issue as the Fatalities Act states that the Medical Examiner must be notified "immediately" if a child in care dies. Alberta legislation ensures that the circumstances of the child’s death in a foster home, or facility, will be reviewed by the Coroner.
The B.C. Coroners Act and policy does not stipulate that the M.S.S. is to be notified of deaths where child abuse and/or neglect may have been a contributing factor. The lack of notification to the M.S.S. may result in the Coroner not being advised of previous child welfare concerns and investigations known to M.S.S. A lack of knowledge of prior concerns may influence the finding of the Coroner as to the cause and circumstances of the death.

Other children in the home may be left at risk if the M.S.S. is not aware of the death and is unable to assess the risk to the children.

**Fatal Child Abuse and Neglect**

The term "battered child syndrome" was first presented by Dr. Henry Kempe and four of his medical associates (Silverman, Steele, Droegemueller and Silver, ) to a pediatric conference in 1961, and published as an article in 1962 in the *Journal of the American Medical Association*. The identification of the battered child syndrome and work done by Kempe and associates is credited with bringing the issue of child abuse to the attention of the public and professionals (Pelton, 1981).

Medical advances, and in particular the Xray, allowed for injuries previously thought to be accidental to be diagnosed as abuse, and for previously undetected causes of death to be detected (ie. shaken baby syndrome). Kempe stated "If only the child could speak, the physician would quickly be led to the proper diagnosis of abuse. To the informed physician the bones tell a story the child is too young or too frightened to tell" (Kempe, et al., 1962). Kempe's work received wide spread media attention (Laird and Harman, 1985) and procedures for reporting child abuse in the
U.S.A. were implemented quickly (Pelton, 1981). Canada followed suite and by the end of the 1960's all provinces had procedures in place for the reporting of child abuse and neglect (Greenland, 1987).

Gil attributes the enactment of legislation mandating the reporting of child abuse as being responsible for researchers being able to obtain data on the numbers of children abused and the circumstances of the abuse. The available data permitted research using large scale surveys and epidemiological studies as research moved beyond case studies to explore the causes of child abuse (Gil, 1970). Included in this research are studies using Coroner’s files to address the issue of fatal abuse and neglect of children.

Adelson published a 1961 study of forty-six homicides in which the victims were infants and preadolescent children. His data had been gathered from the Cuyahoga County Coroner’s Office in Ohio where Adelson was the pathologist and Chief Deputy Coroner. Using Coroner’s files, and records from psychiatrists in prison and hospital settings Resnick’s 1969 study examined one hundred and thirty-one cases of parents killing their children. In 1976 Kaplun and Reich produced a study of one hundred and twelve child abuse deaths gathered from the files of the New York Medical Examiner, public assistance and child welfare offices for 1968 and 1969. Greenland conducted a study of the Ontario Coroner’s files for the years 1973 to 1982. He identified one hundred deaths due to child abuse and neglect. The Ontario findings were published in Greenland’s Preventing CAN Deaths (1987) and included his findings from research into child abuse and neglect deaths in the U.S.A. and U.K. Cooper’s 1994 Wasted Lives used the B.C. Coroner’s files to examine homicides in
families in the lower mainland area of B.C. Her study covered the time period of 1984 to 1990.

Research has also been conducted on fatal child abuse and neglect using other data sources. Gil’s nation wide survey of child abuse Violence Against Children (1970) used reports of neglect and abuse made through legal channels in all American states and territories for 1967 and 1968. In response to the apparent under reporting of fatalities a nation wide press survey was conducted. Homicide statistics for children were researched using the data of the Division of Vital Statistics of the National Center for Health Statistics. Child Deaths in Texas (Texas Department of Human Resources, 1981) used data from the child abuse and neglect reports and child protection agencies records. Death certificates were used in a study of the deaths of children under the age of six years in the first half of 1980 in Childhood Fatalities in New York City, (New York City Mayor’s Task Force on Child Abuse and Neglect, 1983). A Los Angeles study A Profile of Suspicious Child Deaths In Los Angeles County (1986) utilized the ICAN committee’s findings for 1981, 1982, 1983 and 1984. The ICAN committee was a team formed to review all deaths of children aged 10 and younger where child abuse or neglect was suspected.


Researchers caution that not all fatal child abuse and neglect deaths are detected in the studies of the issue. The issue of reporting affects the statistics gathered.

We do not even know how many children are killed by parents and caretakers each year. Such cases are often hard to prove and many physicians and medical examiners are reluctant to get involved by suggesting foul play (Straus et al, 1981).

Gil attributed the lack of reports of fatalities under child abuse reporting mechanisms to the "narrow interpretations of reporting or because of inadequate wording of legislation" (Gil, 1968). He noted that when press clippings in 1967 were compared to 134 officially reported deaths "about 90% of the fatalities known to the press had not entered the official reporting systems" (Gil, 1970).

Greenland found instances of children dying from abuse and neglect in the Coroner’s files that had not been listed in the central register of child abuse. He attributed the lack of registration and recognition of the deaths as child abuse and neglect to the lack of "diagnostic precision" in the definition of the terms "battered child," "child abuse" and "non-accidental injury."

The problem is compounded by the fact that some clinicians and pathologists ignore or neglect to obtain the social evidence that is essential to the diagnosis of death due to child abuse or neglect. On this basis, it seems reasonable to assume that an unknown proportion of infant deaths, currently attributed to accidents, sudden infant death syndrome, or pneumonia, could more accurately be reported as due to abuse, neglect, or some combination of the two (Greenland, 1978).
The data gathered from Coroner's files and other sources on fatal child abuse and neglect provides a picture of the age and gender of the victims, cause of death, abuse and/or neglect prior to the incident causing death and their relationship to the person causing death. Data on perpetrators indicates which group is known to have killed children most often and the methods used.

**Characteristics of Child Victims**

Gil (1970) and Greenland (1973) found that males outnumber females as victims of non-fatal child abuse, but that females were the predominant victims in adolescence.

A majority of the studies of fatal child abuse have also found that male victims out number female victims. The findings have ranged from a few percentage points as in the work of Adelson (1961) and Resnick (1969) to 15% more males than females (Kaplun and Reich, 1976). The New York Study (1983) had the widest range in which males accounted for 64% of the deaths and females for 36%. Cooper (1994) had similar findings, 62% of the victims were male and 38% were female. In most studies the spread was not so dramatic and ranged from 6% to 8%.

Most of the studies did not examine the issue of fatal abuse in children over the age of ten and this may have skewed the findings. As with non-fatal abuse, research of fatal abuse that included adolescents found a higher rate of female victims than male. Kaplun and Reich (1976) included all children under the age of fifteen and found that over the age of ten females outnumbered males two to one.
Straus attributes the higher number of young males as victims of child abuse to the differences in social attitudes between raising boys and girls. Boys are subjected to physical discipline more than girls, but girls are abused in greater numbers as they enter adolescence. He viewed the increased victimization of females as parents reacting to the emerging sexuality of female adolescents (Straus, 1981). Silverman noted that the rate of abuse for males declines in adolescence and speculates that this may be attributable to the ability of a boy to fight back as he grows older and larger (Silverman, P., 1978).

Gil found the age distribution of victims of non-fatal abuse was not as skewed towards the very young as had been suggested in earlier studies (Gil, 1970). While abuse many not be confined to younger children, research has demonstrated that children under the age of five are more likely to be the victims of fatal child abuse and neglect. "Younger children are more likely to be struck by their parents and to be struck more frequently than older children" increasing the risk of serious or fatal injury (Straus et al., 1981).

Findings in studies of fatalities showed that children under the age of five comprise the greatest number of fatalities. Figures ranged from a high of 95% (Greenland, 1987) to a low of 70% (Begin, 1993). Vulnerability appears to decrease as children become older since adolescents accounted for the least number of victims.

The findings reflect the dependency of young children on their parents. Small children, especially infants, are not able to physically defend themselves, or to flee an abusive situation. It is not uncommon for infants and small children to spend the
majority of their time in the home. No suspicion is aroused if they are not seen in public if recovering from injuries inflicted by a parent or caregiver.

When an investigation is conducted, the ability of infants and small children to communicate is limited. The child may not be asked what happened to them. They may be too afraid to tell, may be physiologically incapable of answering, or when they do answer the investigator may not understand what they are trying to verbalize. Investigators tend to rely on the answers of the adults caring for the child for an explanation of how the child was hurt and on medical opinion as to whether the injury could have occurred as described.

An injury may not reflect the degree of force used to harm a child. Zumwalt and Hirsch found that the surface injury may be insignificant in cases of fatal child abuse, especially with regards to blows to the head, trunk of the body, shaking injuries or asphyxiation (Zumwalt and Hirsch, 1980). An investigator may not understand the degree of risk to the child if they are not familiar with injuries in which the surface injury may be negligible, but the potential for internal injury is great (shaken baby syndrome, children hit on the head and blows to the body).

The previous abuse and neglect of the victims has not been documented to the degree that age and gender have. Research has produced a range of findings on the issue. Gil found that over half of the children in his study had been abused previously. He speculated that the actual figure could be "quite likely" over 60% as nearly a quarter of the respondents to his survey did not know if the child had been previously abused or not (Gil, 1970). He stated
It seems that physical abuse of children is more often than not an indication of a prevailing pattern of caretaker-child interaction in a given home rather than an isolated incident (Gil, 1970).

Greenland reported that 10% of the children in his 1973 study had been previously abused, with the number rising to 20% in cases requiring hospital treatment (Greenland, 1973).

Straus found that abuse was a regular occurrence in the abusive families he studied in 1975.

Millions of children each year face parents who are using forms of violence that could grievously injure, maim, or kill them. In many families these episodes of violence are not merely one-shot outbursts. They are regularly patterned ways which parents use to deal with conflict with their offspring (Straus et al., 1981).

Creighton's 1976 study in Britain found that 35.2% of the victims of abuse had been abused previously (Creighton, 1980).

Cooper measured child abuse in relation to the incident causing death and did not examine abuse or neglect that may have occurred prior to the final incident. She identified 7 of the 25 (28%) children in the data she studied as having been victims of child abuse.

The very definition of neglect with an emphasis on its repetitive or continuing nature imparts the notion that a child is neglected over a period of time before concerns are raised (Falconer and Swift, 1983).

Findings of previous abuse or neglect in studies of fatalities range from a low of 20% in the Los Angeles study to a high of 90% (Kaplun and Reich, 1976). The two studies that utilized the Coroner's files and measured prior abuse or neglect showed the highest rates. Greenland found that 63% of the victims has been subjected to
abuse or neglect prior to the incident causing death, while Kaplun and Reich had the highest rate at 90%.

Difficulties in measuring prior abuse and neglect may occur due to possible under-reporting in this area. Coroner’s investigations are intended to determine why a person died, and the death may not have been viewed in a broader context including the possibility of prior abuse and neglect. Reporters may be reluctant to disclose knowledge of prior abuse or neglect as they may be held accountable, particularly in situations where the child has died. Individuals, professionals or agencies may not recognize the signs and symptoms of prior abuse or neglect even after the child has died. No one outside of the home may have been aware of the prior abuse or neglect and the child’s body may not provide clues as to what they previously suffered.

**Cause of Death**

The term "cause of death" refers to the medical reason the child died. Zumwalt, an Ohio Coroner, and Hirsch, a New York Medical Examiner have studied the cause of death in child abuse cases. Both are medical doctors and have used their knowledge of medicine and child abuse to examine how children die at the hands of others. They found that the leading cause of death in their study was physical trauma, specified under six categories: the battered child syndrome, single episode abuse, head injuries, thoracic and abdominal injuries, sexual abuse and soft tissue injuries (Zumwalt and Hirsch, 1980). Battered baby syndrome was estimated to occur in 15 to 20% of the deaths. Single episode abuse was found to be "as common as fatalities
from" battered baby syndrome (Zumwalt and Hirsch, 1980). Single episode abuse was most frequently determined by comparing the explanation for how the child was injured (or killed) with the injury. "A frequent finding in fatally abused children is anatomic-historic disharmony. The injuries found at autopsy could not have occurred in the manner described by the adult guardians" (Zumwalt and Hirsch, 1980).

Head injuries were the third most common form of fatal abuse, followed by thoracic and abdominal injuries. Zumwalt and Hirsch state that the injuries in both classifications may be overlooked as there may be no corresponding marks on the surface of the body. In cases such as these the autopsy becomes an important diagnostic tool.

Sexual abuse is categorized as physical abuse by Zumwalt and Hirsch among others. Fatalities from the sexual abuse by itself are "uncommon," although fatal hemorrhaging may occur. The more common cause of death in sexual abuse fatalities is asphyxial assault (asphyxia occurring in the course of the sexual assault, ie. from the adult's weight on the child's chest)" (Zumwalt and Hirsch, 1980).

Child abuse deaths that are attributed to soft tissue injuries alone are also considered to be "uncommon."

The lethal mechanism in such fatalities include deceptively large Volumes of blood shed into soft tissues, fat embolism generated by crushing of adipose tissue, and stress induced by the cumulative effects of pain (Zumwalt and Hirsch, 1980).

Zumwalt and Hirsch included starvation under the category of neglect. They comment that children who die of starvation while in the home, or after being brought to a hospital emergency ward, are rarely suffering from a natal disease.
Rather the children have not been fed. In addition to severe malnourishment the children may show other signs of neglect, but rarely are indicators of physical abuse found.

Physical and chemical agents are a further category of death. Physical agents include hot water burns and dry burns. Chemical agents may take the form of medicines, alcohol or poisons. The child may be given the substance in a deliberate attempt to kill them, to make them quiet, or as discipline.

The willful failure of a parent or caregiver to provide the basics of life (food, shelter, protection and medical care) to the degree that death is caused is regarded as fatal child abuse. When treatment is withheld or is improper due to the parent's beliefs, "reliance on unfounded methods of treatment, or simple disregard for the child" and death occurs, the situation is regarded as fatal child abuse (Zumwalt and Hirsch, 1980).

Zumwalt and Hirsch comment that Munchausen Syndrome By Proxy is a rare form of child abuse, in which the perpetrators are almost always the mother. The parent seeks attention by repeatedly seeking medical treatment and intervention for the child for non-existent symptoms in a bid for attention. No regard for the harm inflicted on the child by the medical intervention is considered by the parent. The parent may deliberately make the child ill and in some cases has caused the death of the child in a bid for attention for themselves.

The cause of death has not been included in all studies of fatal child abuse. Adelson found that the "methods by which the children were killed differed both quantitatively and qualitatively from the instrumentalities used in adult homicides" as
children are more vulnerable, and physically easier to kill (Adelson, 1961). Adults were more likely to be shot or stabbed, and least likely to be asphyxiated or beaten to death. Asphyxiation accounted for 35% and beating for 32% of the deaths of children in Adelson's study.

Resnick (1969) found that trauma, strangulation and drowning were the most common methods of killing children. He notes that fathers use more "active methods such as striking, squeezing or stabbing," mothers were more likely to drown, suffocate or gas their victims.

Greenland (1987) found that 57% of the deaths in his Ontario study were due to head and brain injuries, neglect and malnutrition accounted for 20%, internal injuries for 10%, asphyxia and choking for 7%. Fractures accounted for 3%, multiple bruising for 3% and other injuries for 6% of deaths. As Greenland recorded more than one cause of death in some cases, the total is greater than 100%. What must be noted is that most of the deaths appear to have been intentional and deliberate in all of the studies. Few were the result of impulsive acts, and in most of the deaths the perpetrator conceivably had time to stop harming the child before death was caused.

Perpetrators

Research has shown that the vast majority of abusers of children are parents, or someone acting in the place of the parent (step-parents, common-law partner of the parent or babysitter) (Schlesinger, 1977). Findings differ however on whether males or females are responsible for more of the abuse. Gil (1970) found that 87% of children who were abused were abused by a parent or parent substitute. In 47.6% of
cases the abuser was the mother or mother substitute, in 39.2% it was the father, or father substitute. Gil cautions that the percentage of female abusers is a reflection of the number of single parent (mother only) families included in his data.

Straus (1981) indicates that mothers were more likely to physically abuse children than fathers. Van Stolk (1972) confirmed this finding, but like Gil, cautioned that the number of single mother households skews the results. Greenland's (1973) research indicated that more men than women had been responsible for the abuse. Parents and parent substitutes made up the majority of the perpetrators.

Schlesinger (1977) raised the issue that while one parent may be involved in the active abuse of the child, the "non-offending" parent may passively condone the abuse.

All studies of fatal child abuse support the findings that a parent or parent substitute is most likely to abuse (and in this case kill) the child. The findings range from 100% of the deaths being attributed to parents or parent substitutes (Resnick, 1969; Cooper, 1994) to a low of 63% (Greenland, 1987).

Mothers were responsible for a range of deaths from 30% (Adelson, 1961) to 67% (Resnick, 1969). Fathers accounted for a range of 33% (Begin, 1993; Cooper, 1994 and Resnick, 1969) to 57% (Adelson, 1961). In two studies, both parents were involved in the deaths. Cooper (1994) found 2.7% of the deaths were caused by the mother and father acting together, while Greenland (1987) found this in 12% of the cases.

The small number of children killed by someone other than the parent were killed by other family members (a grandparent in one case, an aunt and uncle in
another), or by non-relatives (babysitters, adults outside of the home) (Greenland, 1987: Begin, 1994).

That most of the fatalities were caused by someone in a parental role is a reflection of who cares for children. Parents have the greatest degree of contact with children and in particular young children. That very contact may lead to frustration, anger or stress on the part of the parent leaving the child at risk.
CHAPTER 2

METHOD

Introduction

Research was conducted using the files of the B.C. Coroner's Service to ascertain the number of inquests held into child abuse and neglect deaths from 1986 to 1989. Coroner's files of deaths identified as being due to child abuse and/or neglect were examined to determine the characteristics of victims by age and gender, history of prior neglect or abuse, and who knew of the prior risk. The characteristics of perpetrators, their relationship to the child and how the deaths were caused were determined. Data sources used by the Coroner were examined. Names of the deceased children were cross referenced with the M.S.S. file system. The cross referencing was used to determine if the children had been known to the M.S.S. The results were compared to other studies using Coroner's files as a basis of data to determine if the findings were similar. Four inquests were compared to illustrate the differences seen in inquests.

An exploratory, descriptive model of research was used as little research has been done on child abuse and neglect using the Coroner's files as a data base. The files of the Coroner are considered to be public records and are available for legitimate research purposes. Permission was obtained from the Chief Coroner for the Province, J.V. (Vince) Cain, to examine the inquest and inquiry files of children who had died from 1986 to 1989 (inclusive) to identify deaths that appear to have been due to child abuse and/or neglect. The files were examined to determine who had
died, the cause and circumstances of the death and who was alleged to have caused the death. The files were studied to assess whether or not the M.S.S. had been notified of the death, and if M.S.S. files had been used in the inquest or inquiry.

Permission was granted by the M.S.S. for the names of children identified in the Coroner’s files to be checked against the Ministry’s electronic file system. The names were cross checked to determine if the risk to the deceased child had been known to the M.S.S. prior to or at the time of the child’s death, as the M.S.S. is mandated to protect the children of the Province from abuse and neglect.

The Coroner’s Service and the M.S.S. stipulated that the names of the children and families must remain confidential. Care has been taken to not use names of the deceased or to identify the communities in which they died. Media coverage may have made some of the deaths recognizable to readers despite the measures taken to limit the information in the case histories (appendix 1).

An attempt was made to balance the information presented to provide a complete picture of the death, while limiting any potentially identifying information as much as possible.

The Coroner’s Service maintains files on all inquests and inquiries in B.C. Files are stored at the Provincial office in Burnaby for four years, after which they are archived for perpetuity.

The Coroner’s Service policy stipulates that while the files are public records, no mechanical copies may be made of the files. Information may be gathered by physically writing out what is contained in a file, or by speaking into a tape recorder.
Data for this project was gathered by hand and recorded on data collection sheets (Appendix B).

**Definition of Child**

The legal definition of a child in B.C. as anyone under the age of nineteen years of age was used for the purposes of this study. In all but one case, which was the death of a viable fetus in utero, the children were born and lived physically separate from the mother before their death. In the exceptional case the Coroner found the death to have been caused by the father repeatedly kicking the mother in the stomach to specifically kill the child. The file was included as the Coroner had classified the death as the homicide of a child.

**Definition of Physical Abuse**

A modified version of Gil's definition of physical abuse has been used for the purposes of this study. Gil defines physical abuse as

... the intentional, nonaccidental use of physical force, or intentional, nonaccidental acts of omission on the part of a parent or other caretaker [or caregiver] interacting with a child in his care, aimed at hurting, injuring or destroying that child (Gil, 1970).

The definition has been modified to include persons in noncaregivers roles to recognize the abusive attacks on children committed by those who may have access to a child, but who are not by definition a parent or caregiver. The definition of a noncaregiver includes a person who is in a relationship with the parent, but does not live in the home (a boyfriend or girlfriend of the parent) or someone whom the
parent permits to have access to the child (a family friend). Included in the definition would be someone who sought access to the child without the parent’s consent, or possibly even knowledge, with the intent of harming the child. Although the majority of child abuse is inflicted by a parent, or someone in a parental role, it must be recognized that unrelated offenders also abuse and kill children. Gil’s definition is thus modified as

... the intentional, nonaccidental use of physical force, or intentional, nonaccidental acts of omission on the part of a parent, other caretaker, or caregiver, or person in a noncaregiver role interacting with a child, aimed at hurting, injuring or destroying that child.

Each death was reviewed to determine if the child was a victim of child abuse or neglect. A 6 year old girl was raped and drowned by an unrelated male who lived outside of the home. As she was vulnerable due to her age and proximity to an offender willing to rape and kill a small child her death was included in the study. In comparison an 18 year old female killed by her former boyfriend does not fit the definition. The victim had been in an adult relationship with the perpetrator. Her vulnerability was not based on her being a child, but rather on her adult relationship with an abusive male.

For the purposes of this study sexual assault causing death has been included as a further classification of physical abuse where the actual act of sexually abusing the child caused death. In 87/09 the child was asphyxiated by an adult male who raped her. The actual penetration of the vagina did not kill her, but the compression of her chest by the assailant on top of her during the rape caused death by asphyxiation.
Care has been taken to differentiate the cases where the child was sexually assaulted, but the sexual assault did not cause the death. In case 87/06 the child was raped and then drowned, while in 88/07 the child was drowned and then raped. The children in 87/03 and 87/04 were killed by blows to the head and sexually assaulted at the time of, or shortly after death. In all 4 cases the children appear to have been killed to prevent them from reporting the sexual abuse, or to render them incapable of stopping the abuse, but the sex act itself was not the cause of death.

**Definition of Neglect**

Polansky's definition of neglect has been used

Child neglect may be defined as a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities (Polansky, et al, 1975).

The "inattentiveness" of the parent may be due to a lack of knowledge, ability, skill or resources. The key to the situation being defined as neglect is that the parent is not attentive to the child's needs despite the clear needs of the child. Neglect may occur in combination with physical abuse, or as a separate phenomenon.

Neglect in combination with physical abuse is seen in 89/06 where the eleven month old child was diagnosed as failure to thrive due to severe malnourishment before her death, but the cause of death was bronchial pneumonia due to drowning. A similar pattern was seen in 87/07 where a seven month old child was diagnosed as failure to thrive at three months of age and was "malnourished" at
the time of death. The actual cause of death was a ruptured stomach which the pathologist speculated was "likely" caused by blows to her buttocks while she was held over an adult's knee and "spanked."

The weakened physical condition of the children may have lessened their chances of surviving the physical injuries inflicted on them. Neglect prior to the death is an indicator of the degree of risk that existed for the child while they were alive.

The Study

The study was limited to the years 1986, 1987, 1988 and 1989 as the Coroner's files for these years were available on site at the Chief Coroner's office at the time of the data collection.

Files were located with the assistance of the Chief Coroner's Office in Burnaby. The Coroner's Service provided a printout of all deaths for persons under the age of 19 years for the years of the study. The list included the names of the deceased, the Coroner's case number, how the death had been classified (accidental, homicide, natural, suicide and undetermined), the COD (cause of death) code used by the Coroner's Service, the means of death code and the age of the deceased.

Natural death is defined by the Coroner's Service as "death primarily resulting from a disease of the body, and not resulting secondarily from injuries or abnormal environmental factors."
Accidental death is defined as "death resulting from an action or actions by a person causing death to himself, or a death that results from the intervention of a nonhuman agency."

Suicide is defined as "death resulting from self-inflicted injury, with apparent self-intent to cause harm" (B.C. Coroners Service Policy, 1989).

The definition for homicide varied over the years covered by this study. The 1986 definition was "death resulting from injuries caused directly or indirectly by the actions of another person, without imputing blame or fault to that person." (B.C. Coroners Service policy, 1989). The definition used in 1987 and 1988 was "death resulting from injuries inflicted by another person or persons with the intent to injure or kill, by any means." (B.C. Coroners Service policy, 1987). The Coroners Service returned to the 1986 definition of homicide in 1989 and has continues to use the definition (B.C. Coroners Service Policy, 1989).

Deaths in which an individual was killed by another person or persons without intent to harm or kill were listed as accidental for 1987 and 1988 lowering the number of homicide cases listed for those years. The change in the definition of homicide is reflected in the number of deaths listed as homicides for the period of the study. The number of deaths classified as homicides in 1986 was 297, in 1987 the total was 98, for 1988 the total was 109 and in 1989 the total was 305.

The Coroners Service provided coding sheets to identify the cause of death codes, divided between natural deaths and unnatural deaths. The physical cause of death was identified as the actual illness or condition in natural deaths (ie.
pneumonia, congenital defects) or the act that caused death in unnatural deaths (strangulation, poisoning).

The means of death describes the circumstances of the death such as motor vehicle accidents, falls, deaths involving animals and fire arms.

**Criteria For Inclusion**

All deaths classified as homicide, undetermined and suicide, and every tenth file of deaths classified as natural and accidental were examined to determine if child abuse and/or neglect had been a factor in the death, or if the death appears to have been incorrectly classified.

Each death classified as homicide was examined on the rationale that if the child's death was recognized as having been caused by another person it would be classified as homicide.

All deaths classified as undetermined were examined as child abuse deaths can be difficult to detect and the cause of death may not have been determined. The finding may have been complicated by the alleged assailant and/or non-offending parent being unwilling to provide information on how the death occurred. As child abuse deaths occur in the privacy of the home more than any other location the lack of corroborating testimony may make a finding difficult, if not impossible.

Suicides were examined to eliminate the possibility of a child's death being made to appear to be, or mistaken for, suicide.

All Sudden Infant Death Syndrome deaths were examined to determine if any deaths that did not fit the pattern of Sudden Infant Death Syndrome had been listed
as such. The one Sudden Infant Death Syndrome included in the study has been classified as an undetermined death. Jaffe (1990) indicates that pathologists must use care when reaching a diagnosis of Sudden Infant Death Syndrome as infants are easily suffocated and strangled with little physical evidence to indicate the cause of death. He cautions that a diagnosis of Sudden Infant Death Syndrome entails the elimination of any other cause of death as a first step. The pathologist must utilize skill in detecting the sometimes subtle physical signs of abuse that can lead to death. The circumstances of the death are important in determining the cause of death. The explanation for how the death, or injury causing death, occurred is important in determining the likelihood of the death having happened in the manner described. Jaffe writes that infants may suffer fatal brain damage from being shaken, but that the parents may present an explanation of Sudden Infant Death Syndrome. The explanation of the circumstances of the death may not fit the known pattern of Sudden Infant Death Syndrome and trauma to the brain may be revealed at autopsy.

Each file meeting the selection criteria was read in full. The file contents varied to a degree depending on whether an inquiry or inquest had been held. All files contained a Judgement of Inquiry written by the Coroner presiding over the inquiry or inquest. An autopsy report completed by the attending pathologist and pictures of the deceased taken at the scene of death and/or in the morgue were on each file.

The files of deaths examined by inquiry tended to be more concise and to contain less information from outside agencies or sources as the cause of death appeared to be less complex and more readily determined.
Deaths that went to inquest varied from succinct examinations of death in which information was readily available and few outside sources needed to be utilized, to very complex inquests in which a multitude of witnesses testified and numerous records were entered as evidence.

Police reports were contained on the file. The police reports ranged from reports summarizing the investigation, to more complete investigative records, depending on the complexity of the investigation. The Coroner's files did not contain the complete police files.

Information from other agencies and individuals was on some files. The information sources used by the Coroner varied according to the cause and circumstances of the death. Information had been gathered from hospitals, doctors, the M.S.S., schools, emergency medical teams, mental health professionals, family friends, relatives, neighbours and in one instance news reporters.

The information was read to determine if there had been any suspicion of child abuse and/or neglect in the investigative process conducted by the police, or in the findings of the inquiry or inquest. Particular care was taken to determine if evidence was available that confirmed the death had been caused by abuse and/or neglect. The autopsy reports of some of the deaths clearly stated that the death had been due to abuse based on the physical evidence observed by the pathologist. Several autopsy reports noted the obvious malnourishment of the child and the lack of a medical condition for the malnourishment. Police reports contained statements from offenders and non-offending parents as to how the child had been abused and killed.
The determination of whether the death was included in the study as being
due to abuse or neglect was arrived at by using several criteria. The files ranged from
deaths in which a finding was made that the death was clearly due to abuse and/or
neglect to less specific determinations of the cause of death.

All cases wherein the pathologist or Coroner made a finding that the death
was due to abuse or neglect were included. The deaths listed in this manner were
clearly abuse deaths in which the child had suffered repeated injury at the hands of a
caregiver. There was a total of 6 deaths in this category.

Deaths of children classified as homicides by the Coroner were included if
they fit the definition of abuse in that the death had been deliberately caused by
another person. Twenty-four deaths fit this category.

All cases where the forensic and scene of death evidence indicated that the
death was due to abuse and did not occur in the manner described to the
investigators were included. The explanation given for the death of the child in 88/08
did not fit the physical evidence. An autopsy showed that the three month old infant
had skull fractures, an injury to the left humerus (upper arm), multiple bruises to the
scalp and brain swelling. The injuries were determined to have occurred at least three
days prior to death. Initially the mother gave a statement to the police that she
repeatedly threw the child into the crib, the statement was apparently obtained
incorrectly and the mother altered her explanation. She claimed that her four year old
daughter had caused the injuries and that she had only confessions to "protect" the
four year old. The pathologist found that the injuries could not have been caused by
the four year old due to her limited strength and that the injuries were consistent with
the initial statement of the mother. In 87/08 the step-father of a two and a half year old boy claimed to have been carrying the child upstairs when he tripped and fell on the child. The child’s mother initially supported her common-law husband’s explanation. A pathologist found extensive injuries at the autopsy that were determined to have been inflicted on "at least four separate occasions." The injuries were not consistent with the explanation given and were considered to be "characteristic of child abuse" by the pathologist. There were three deaths in this category.

All cases where no explanation was offered for how the child had been injured, but the physical evidence and risk factors indicated that the child had been abused and/or neglected were included. The mother of the child in 87/11 gave virtually no explanation as to how the child came to be dead in his bedroom. When she was pressed for specifics by the investigators she provided partial (but improbable) answers such as the child banging his head until he fell asleep causing bruises to his forehead. The cause of death was not determined, but multiple risk factors were evident. The initial police explanation left many unanswered questions as to how the child was killed, and the autopsy did not determine a cause of death. (For a more detailed explanation of the death see Appendix A). Two deaths fit this category.

To determine if there had ever been any reported child welfare concerns the names of the deceased children, parents, caregivers and other children in the home were cross checked on the M.S.S. electronic file system M.S.S. file types include
Child In Care (C.I.C.) files, Family Service (F.S) files and Income Assistance (G.A.I.N.) files.

The electronic file system indicates which files are open, the names on the files and the original date of opening, and most recent date of closing (if closed). It is not possible to determine how often a Family Service or Child In Care file has been opened or closed from the electronic system alone. There is no access to the contents of the file recordings via the electronic system. It is best described as a computerized file system.

Names were checked to determine if the M.S.S. had provided services to the family prior to, at the time of the death, or in response to the death. Files were checked to determine if the child had ever been in the care of M.S.S. by agreement or court order resulting in a Child in Care file. The files were searched to determine if a Family Service file had ever been opened in the name of any adult in the home, or if any children had ever been included on a Family Service file of their parent, caregiver, or any other adult.

Research has indicated a correlation between poverty and child welfare concerns. As such a search was conducted to determine if the family had ever been in receipt of Income Assistance through the M.S.S. as an indicator of possible poverty.

Analysis

Data was cross tabulated to determine how many deaths of children the Coroner examined as compared to the total number of inquests and inquiries
conducted in each year of the study. The data was further analyzed to determine what portion of the deaths of children were due to each classification used by the Coroner; suicide, accidental, natural, homicide and undetermined. The deaths were than cross tabulated to determine what portion of the homicides were in fact motor vehicle accidents (and not child abuse or neglect deaths), and what portion were caused by another person (potential child abuse and neglect deaths). The deaths identified as being due to abuse and/or neglect were further categorized by the four categories of criteria used to determine if the death was due to abuse and/or neglect.

Data was cross tabulated by year of death and gender to illustrate how many children of each gender died in each year, and in total for the four years of the study. The findings with regards to the gender of the children were then compared to other studies of fatal child abuse that had used Coroner’s files as the source of data.

Deaths were cross tabulated by year and the age of the victim to determine which age of children are most at risk. The findings were then compared to other studies using the Coroner’s data. Cross tabulation was done of the deaths by the perpetrator and the results compared to other studies. Deaths were broken down by the perpetrator and the year of death, the cause of death and age of the victim, the cause of death and the perpetrator, and the perpetrator by the age of the victim to determine who children are at risk from and if the risk differs depending on the age of the child.

Four cases were described in detail to illustrate the differences in ways that inquests were conducted. Case A was very thorough and determined who caused the deaths of the children involved. Case B was an inquest that was thorough, but could
not determine who caused the death. Case C was an inquest in which the police investigation was criticized and which may have contributed to the perpetrator not being identified. And case D was an inquest in which potential sources of information appear to have not been used by the police or the Coroner. These sources not utilized may have been able to provide information that may have altered the Coroner’s findings of an undetermined death.

Data Limitations

The total number of child abuse and neglect deaths for 1986 to 1989 are under represented in the present study. Coroner’s files can not be assumed to contain all child abuse and neglect deaths for the time period studied. The population represented in the Coroner’s data consists of those children who’s deaths were reviewed by the Coroner. If criminal charges had been laid in the death of a child the Coroner is not able to proceed with an inquest or inquiry until the criminal matter is resolved (Section 23 (1), Coroners Act, 1979). Thus deaths recognized as child abuse or neglect may have proceeded through the criminal justice system and not appear in the population for this study.

Deaths that were not recognized as being due to child abuse and neglect may not have been reported to the Coroner. A death may have been attributed to natural and accidental causes when in fact the child had been abuse or neglected.

In light of Judge Gove’s recent report into the death of five year old Mathew Vaudreuil it must be noted that the intent of this study is to examine child abuse and neglect deaths into which inquiries or inquests were held by the B.C. Coroners
Service. The report by Judge Gove is broader and includes deaths that appear to have not been reported to the Coroner.
CHAPTER 3

RESULTS

Total Number of Coroner’s Files

The total number of deaths in B.C. for the years of the study was compared to
the number of deaths reviewed by the Coroner. Table 1 illustrates that the percentage
of deaths reviewed by the Coroner ranged from 63% to 67%.

Table 1: Coroners cases as a % of total registered deaths in B.C.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Deaths B.C.</td>
<td>8380</td>
<td>8563</td>
<td>8685</td>
<td>9062</td>
</tr>
<tr>
<td>Non-Coroner Cases</td>
<td>2774</td>
<td>2918</td>
<td>3010</td>
<td>3342</td>
</tr>
<tr>
<td>Coroner’s Cases</td>
<td>5606</td>
<td>5645</td>
<td>5675</td>
<td>5720</td>
</tr>
<tr>
<td>Coroner’s Cases % Total Deaths</td>
<td>66.9%</td>
<td>65.9%</td>
<td>65.3%</td>
<td>63.1%</td>
</tr>
</tbody>
</table>

Total Number of Deaths of Children in B.C.

The deaths of persons fitting the legal definition of a child (eighteen years of
age or younger) were isolated from the total number of deaths reviewed by the
Coroner in B.C. Table 2 shows the total number of deaths of children in B.C.
reviewed by the Coroner for the years of the study as a percentage of the total
number of Coroners cases.
Table 2: Deaths of children as a % of Coroners cases

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Coroners Cases</td>
<td>5606</td>
<td>5645</td>
<td>5675</td>
<td>5270</td>
</tr>
<tr>
<td>Total Cases ≤ 18</td>
<td>289</td>
<td>347</td>
<td>342</td>
<td>335</td>
</tr>
<tr>
<td>Ages ≤ 18 as % of Coroners Cases</td>
<td>5.2%</td>
<td>6.2%</td>
<td>6.0%</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

Deaths of children account for a range of 5.2% to 6.2% of the total number of deaths reviewed by the Coroner.

Deaths of Children by Coroners Classification:

Deaths are classified by the Coroner as suicide, accidental, natural, homicide or undetermined. The deaths of children were examined according to the classification system as illustrated in Table 3.

Table 3: Deaths of Children By Coroners Classification

<table>
<thead>
<tr>
<th>Year</th>
<th>1986</th>
<th>1987</th>
<th>1988</th>
<th>1989</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td>21</td>
<td>13</td>
<td>27</td>
<td>26</td>
<td>87</td>
</tr>
<tr>
<td>Accidental</td>
<td>133</td>
<td>171</td>
<td>162</td>
<td>105</td>
<td>571</td>
</tr>
<tr>
<td>Natural</td>
<td>77</td>
<td>139</td>
<td>129</td>
<td>129</td>
<td>474</td>
</tr>
<tr>
<td>*Homicide</td>
<td>50</td>
<td>20</td>
<td>20</td>
<td>61</td>
<td>150</td>
</tr>
<tr>
<td>Undetermined</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>14</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>289</td>
<td>347</td>
<td>342</td>
<td>335</td>
<td>1313</td>
</tr>
</tbody>
</table>

*Definition of homicide altered in 1987 and 1988 to include only deaths intentionally caused by another person
The definition of homicide for 1987 and 1988 included only deaths where the intent to cause death existed. The 1986 definition of a death caused by an individual, whether intentional or not, was returned to in 1989. The differing definitions is reflected in the number of deaths classified as homicides for 1987 and 1988 being lower than the number for 1986 and 1989. The greatest difference is that motor vehicle accidents causing death were not included as homicides in 1987 and 1988 if the intent to cause death was not apparent. The change in the definition of homicide does not influence the number of child abuse deaths identified.

Table 3 illustrates that accidents form the greatest proportion of deaths of children reviewed by the Coroner. Natural deaths form the second largest proportion, followed by homicides, suicides and deaths classified as undetermined.

Homicides and Motor Vehicle Homicides of Children

In Table 4 the motor vehicle homicides of children are separated from the homicides of children that did not occur in motor vehicle accidents. The total non-motor vehicle homicides include twenty-four deaths that appear to be due to child abuse or neglect.

The category of non-motor vehicle homicides of children also includes the deaths of children that do not appear to have been due to abuse or neglect. Deaths in this category include the shooting of a sixteen year old male by a gang member, the killing of an eighteen year old female by a former boyfriend and the accidental shooting of an eleven year old boy by his brother.
Table 4: Homicides versus Motor Vehicle Homicides for Children:

<table>
<thead>
<tr>
<th>Year</th>
<th>1986</th>
<th>1987</th>
<th>1988</th>
<th>1989</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MVA Homicides</td>
<td>38 (76%)</td>
<td>7 (37%)</td>
<td>5 (25%)</td>
<td>40 (66%)</td>
<td>90 (60%)</td>
</tr>
<tr>
<td>Non-MVA Homicides</td>
<td>12 (24%)</td>
<td>12 (24%)</td>
<td>15 (75%)</td>
<td>21 (34%)</td>
<td>60 (40%)</td>
</tr>
<tr>
<td>Total Deaths</td>
<td>50 (100%)</td>
<td>19 (100%)</td>
<td>20 (100%)</td>
<td>61 (100%)</td>
<td>150 (100%)</td>
</tr>
</tbody>
</table>

It is important to differentiate between homicides caused by motor vehicle accidents, and homicides not caused by motor vehicle accidents to obtain a clear picture of the number of non-motor vehicle homicides of children the Coroner investigates. Deaths due to child abuse and neglect tend to be classified as non-motor vehicle homicides.

Motor vehicle homicides account for the majority of homicides of children investigated by the Coroner. The total number of child non-motor vehicle homicides for the period of study represents 4.6% of the total deaths of children reviewed by the Coroner.

Child Abuse and Neglect Deaths


The 35 identified child abuse and/or neglect deaths account for 2.7% of the total 1313 deaths of children reviewed by the Coroner. The 35 deaths account for 23% of the total 150 homicides of children. When compared to the total non-motor vehicle homicides however the 35 deaths identified as child abuse and/or neglect
account for 58% of the 60 deaths. The 25 (42%) remaining non-motor vehicle deaths represent the deaths of children by other individuals in situations that did not fit the criteria of child abuse and/or neglect.

Child abuse and neglect deaths thus account for more than half of the homicides of children that did not occur in motor-vehicle accidents that are investigated by the Coroner.

Identification of Child Abuse and Neglect Deaths by Criteria

Each death was examined to determine if it fit the criteria of this study for a child abuse or neglect death.

Table 5 indicates how the death were classified.

Table 5: Classification of Child Abuse/Neglect Deaths by Criteria

<table>
<thead>
<tr>
<th>Classification of Death</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Abuse Noted</td>
<td>6</td>
<td>17.1</td>
</tr>
<tr>
<td>Death Fits Definition</td>
<td>24</td>
<td>68.6</td>
</tr>
<tr>
<td>Explanation Incongruent With Evidence</td>
<td>3</td>
<td>8.6</td>
</tr>
<tr>
<td>No Explanation, But Evidence</td>
<td>2</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>100</td>
</tr>
</tbody>
</table>

Six files contained a statement made by the pathologist or Coroner that the death was due to abuse or neglect. In three of the instances, infants died from head injuries suffered when they were shaken. Two children were beaten and one was
thrown against the wall. The injuries to the children were severe and clearly identifiable as child abuse from the autopsy and circumstances of the death. Physical evidence was found at the autopsy (partially healed fractures, old fractures, bruises of differing ages) that indicated that the children had been abused prior to the incident causing death.

Twenty-four deaths were listed as homicides. The deaths included seven children who had been shot by the father, three who were drowned by the mother, four who were killed in fires lit by the mother, three strangled by the mother, one infant smothered by the mother, five killed prior to, during, or after a sexual assault, and one infant killed in utero when the father beat the mother to cause the child's death. The classification of the death as a homicide by the Coroner appears to have been based on the specific incident that caused the child's death, rather than a review of the child's life to determine if the child had been abused or neglected on more than one occasion. Information in the Coroner's files indicated that eighteen of the twenty-four children appear to have been abused or neglected prior to the incident causing death.

There were three deaths identified in which the explanation for the injury causing death did not fit the physical evidence found at the autopsy. One child was drowned and had bruises to his face. His adoptive mother offered a variety of improbable explanations for his death, including that he had died of a seizure when there was no evidence of the child ever having a seizure. One child suffered multiple skull fractures. The mother recanted her confession of having thrown the infant into the crib repeatedly and claimed that the four year old sibling had injured the infant
and the mother "confessed" to "protect" the four year old. The autopsy found that the injuries could not have been caused by the four year old and were consistent with the original explanation given by the mother. One infant died of a ruptured stomach caused by blows, the parents claimed she had died of Sudden Infant Death Syndrome. The child was found to be severely malnourished at the autopsy and she appeared to not have been fed.

In two instances no clear explanation was offered for the child's death, but multiple risk factors were present. One child was found dead in his bedroom with a bruise on his forehead. The mother was vague as to how he may have been bruised and appears to have either avoided specific questions about the child's death, or she was not asked. A child died at the age of fifteen months after he is alleged to have quit breathing. A sister had died at the age of four months and the death was attributed to Sudden Infant Death Syndrome. Three other children in the family (not clear if this was the immediate or the extended family) had allegedly died of unknown causes.

Characteristics of the Victims

The deaths were examined to determine who had died and if there were any common characteristics in the deaths.

Gender

The deaths were examined to determine the gender of the children who had died. Table 6 examines the number of deaths of each gender in each year of the study.
Table 6: Deaths by Year by Gender

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>4</td>
<td>4</td>
<td>8 (23%)</td>
</tr>
<tr>
<td>1987</td>
<td>4</td>
<td>7</td>
<td>11 (31%)</td>
</tr>
<tr>
<td>1988</td>
<td>7</td>
<td>3</td>
<td>10 (29%)</td>
</tr>
<tr>
<td>1989</td>
<td>3</td>
<td>3</td>
<td>6 (17%)</td>
</tr>
<tr>
<td>Totals</td>
<td>18 (51%)</td>
<td>17 (49%)</td>
<td>35 (100%)</td>
</tr>
</tbody>
</table>

The results indicate that boys and girls were killed in almost equal numbers for the period of the study. There was a total of one more male than female victim.

Table 7 compares the findings of eight other studies using Coroner’s files as a source of data to the results of this study using the B.C. Coroners Service data. The studies were conducted in a variety of jurisdictions in the United States and Canada.

Table 7: Fatalities by Gender: A Comparison of Studies

<table>
<thead>
<tr>
<th></th>
<th>Number Deaths</th>
<th>Male %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Study</td>
<td>35</td>
<td>51</td>
<td>49</td>
</tr>
<tr>
<td>Greenland</td>
<td>100</td>
<td>54</td>
<td>46</td>
</tr>
<tr>
<td>Resnick</td>
<td>131</td>
<td>49</td>
<td>51</td>
</tr>
<tr>
<td>Kaplun and Reich</td>
<td>112</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>Texas Study</td>
<td>267</td>
<td>46</td>
<td>54</td>
</tr>
<tr>
<td>New York Study</td>
<td>45</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>L.A. Study</td>
<td>123</td>
<td>54</td>
<td>46</td>
</tr>
<tr>
<td>Stats. Canada (Begin)</td>
<td>542</td>
<td>53</td>
<td>47</td>
</tr>
<tr>
<td>Silverman and Kennedy</td>
<td>620</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>
Of the eight studies examined only two show a spread of more than 8% between the number of males and females who were killed. In six of the eight studies the percentage of males was greater than the percentage of females.

The present study using B.C. Coroners Service data was consistent with this finding in that slightly more males (51%) than females (49%) were victims of fatal child abuse.

**Gender and Age as Variables**

When age and gender are examined males appear to be more vulnerable than females as small children. Table 8 illustrates the deaths by year by age and by gender.

<table>
<thead>
<tr>
<th></th>
<th>&lt; 12 Months</th>
<th>1 to 5 Years</th>
<th>≥ 6 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>1986</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>1987</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>1988</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>1989</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>4</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

Total < 12 months = 9  
Total 1-5 Yrs. = 19  
Total ≥6 Yrs. = 7  
Total = 35

Males outnumber females in the under 12 months age group and in the 1 to 5 year old age group. When the age of the victims is examined it is clear that children
under that age of 5 make up the majority of the victims. The largest concentration is in the 1 to 5 year old category.

Table 9 is a comparison of the findings in the present study and other studies of fatal child abuse with regards to the age of the victims.

**Table 9: Fatalities by Age: Comparison of Studies**

<table>
<thead>
<tr>
<th>Study</th>
<th>Number of Deaths</th>
<th>Youngest Classifications</th>
<th>Older Classifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Study</td>
<td>35</td>
<td>80% ≤ 5 Years</td>
<td>20% ≥ 20%</td>
</tr>
<tr>
<td>Adelson</td>
<td>46</td>
<td>66% ≤ 6 Years</td>
<td>34% ≥ 7 Years</td>
</tr>
<tr>
<td>Kaplum and Reisch</td>
<td>112</td>
<td>82% &lt; 5 Years</td>
<td>18% ≥ 5 Years</td>
</tr>
<tr>
<td>U.S. Study</td>
<td>1000</td>
<td>75% ≤ 5 Years</td>
<td>25% ≥ 6 Years</td>
</tr>
<tr>
<td>Texas</td>
<td>267</td>
<td>79% &lt; 5 Years</td>
<td>21% ≥ 7 Years</td>
</tr>
<tr>
<td>Daly and Wilson</td>
<td>158</td>
<td>100% &lt; 12 months</td>
<td>Study of Infanticide</td>
</tr>
<tr>
<td>Greenland</td>
<td>100</td>
<td>95% &lt; 5 Years</td>
<td>5% ≥ 5 Years</td>
</tr>
<tr>
<td>L.A. Study</td>
<td>123</td>
<td>93% &lt; 5 Years</td>
<td>7% ≥ 5 Years</td>
</tr>
<tr>
<td>Stats Canada (Begin)</td>
<td>542</td>
<td>70% &lt; 5 Years</td>
<td>30% ≥ 5 Years</td>
</tr>
</tbody>
</table>

The studies clearly illustrate that children under the age of five are most often the victims of fatal child abuse. The findings of the present study using B.C. Coroners Service data are consistent with the findings of the studies on fatal child abuse. Younger children are clearly more vulnerable and represent a larger portion of the children who die from abuse and neglect.
Prior Abuse and Neglect

Ten of the 35 deaths had no known or recorded indication of prior abuse or neglect. In 25 of the cases there was a clear indication on the Coroner’s files that the child had been previously abused and/or neglected. Prior risk to the child appears to have been known by other adults (most often the non-offending parent) in all 25 of the cases.

The determination of prior risk to the child is important as it illustrates that previous attempts by the M.S.S. or family members to protect the child may not have been sufficient. That a non-offending parent or other adult in the home was aware of risk to the child and did not intervene raises concerns as to what extent non-offending adults in the home can be assumed to be aware of the risk to a child and their ability to offer effective protection.

The mother apparently was aware that the child was being harmed or was at risk of further harm in 14 cases. Mothers varied in their responses to the risk.

The efforts of one mother to protect her four children proved to be futile. She had separated from the father and was meeting with him to discuss custody of the children. He beat and terrorized her while threatening that if she sought help he would kill the children. He followed through on his threat and then committed suicide.

A mother killed two of her children in apparent desperation to "protect" them after she was informed that her husband was to be released from prison. The father had previously sexually abused the children and the mother appeared to view death as the only way she could ensure that he would not harm the children, or herself,
again. One child survived the fire set by the mother, the mother and two youngest children died.

In the remaining eight cases the mothers appeared to know of the risk to the child and from the evidence presented at the inquest did not intervene to adequately protect the child. The mother of two children voluntarily took them to visit their father even though he had a history of violence directed at herself and the children that had caused her to leave the home shortly before the deaths. He shot and killed the children during the visit in a murder/suicide.

A mother was aware that her teenage common-law husband was a violent alcoholic. She appears to have been aware that he had shaken the infant prior to the incident that caused the child’s death, but had not intervened. It is not clear from the Coroners file if she understood the degree of risk posed to the child by shaking.

In a separate case a two month old infant was shaken by the father. Testimony was heard from the mother that she had heard the incident during the night and did not get up to check on the child despite hearing "gagging" sounds. The mother appeared to have been aware that the father had harmed the child on previous occasions. She was described as "young" at the inquest.

The mother of a six month old boy did not intervene despite being aware that her male room mate was physically abusive of the child. He shook the child to death.

In one instance the mother of a nine month old boy voluntarily allowed the non-custodial father to take the child for an overnight visit despite the father being intoxicated when he arrived at her home. She was aware that he had a history of
depression and had told others that he wanted "revenge" as the mother had custody of the child. He shot the child and then killed himself.

In two cases the mothers of infants appear to have been aware that their common-law husbands were physically abusive of the child and did not intervene.

While the possibility exists that the mother's may have been immobilized to protect their children due to threats or violence directed at themselves by the perpetrator this can not be assessed using the Coroner's files. The issue does not appear to have been raised in most of the inquests.

In 5 of the deaths the fathers appear to have been aware of the risk to the child. A mother was convicted of beating her three month old daughter to death. The father appears to have been aware of the abuse, and may also have abused the child.

Two children were drowned by their mother who appeared to have psychiatric problems. Although the children had told the father that the mother was "bad" and was "hurting" them it is not clear if he understood the degree of risk possessed by the mother.

A five year old boy was drowned and the adoptive mother implicated in his death. While the adoptive father, teacher and Public Health Nurse were all aware that the child was physically abused by the mother no report was made to M.S.S..

A three month old girl was beaten on at least two occasions by the mother. The father appears to have been aware of the injuries to the child.

In 5 cases both parents presented a risk to the child, leaving no one to offer any form of protection. Three of the deaths involved parents who were heavy
substance abusers. A three year old girl was raped and drowned by an adult male friend of the parents. The friend and parents had been drinking heavily on the night of the assault and the parents were not aware the child had been taken from the house and killed.

An unborn male child was killed from blows the father inflicted on the mother to cause the child’s death. Both parents were heavy abusers of alcohol and street drugs. The child was delivered three days after his death and had a blood alcohol reading of .18 (legal impairment in B.C. is .08).

A three year old girl was sexually assaulted with a broom handle and raped by a man living with her alcoholic mother. Evidence was presented that the mother was in the house and drinking heavily the night of the assault. Death was caused by asphyxiation due to the compression of the chest during the rape.

Both parents appear to have presented a risk to the child in two cases where substance abuse did not appear to be a factor. A severely malnourished eleven month old girl drowned. Although the mother was suspected of causing the child’s death, evidence was presented that both parents had not fed her, or kept court ordered medical appointments.

A severely malnourished seven month old girl died of a ruptured stomach. The father was suspected of having physically assaulted the child, both parents were suspected of having not fed her.
M.S.S. Involvement

Five of the 25 children who had suffered previous abuse and/or neglect had been in the care of the M.S.S. and returned to their parent(s) prior to their death. A malnourished infant was apprehended by M.S.S. and returned by the court to the parents under an interim supervision order. She was found drowned and severely malnourished two and a half months later while still under the supervision order. The M.S.S. was criticized in the inquest for not having provided adequate supervision to ensure the safety and well being of the child.

Four children were returned to their parent(s) by the M.S.S. in the months preceding their deaths. A five brother and a twelve year old sister had been in care due to the alcohol related neglect by both parents. Within four months of the children returning home the parents separated as the father was violent, abusing alcohol and drugs and physically abusive of the mother. During a weekend visit to the father the children were shot and killed in a murder/suicide. M.S.S. was criticized at the inquest for not maintaining a Family Service file, assessing the degree of risk, or providing services after returning the children home.

A two and half year old boy was beaten to death by his mother’s common-law husband within two months of being returned home. The autopsy indicated the child had multiple bruises of varying ages on his body. He had been physically abused on numerous occasions during the two months he was in his mother’s care.

A ten year old boy was strangled by his mother. He had been in the care of M.S.S. on two previous occasions due to the mother’s psychiatric problems and the
resulting neglect of he and his twelve year old brother. The child was killed within three months of being returned home.

Two children were apprehended by the M.S.S. in response to the injuries that later caused their death. There was no implication that the deaths were due to anything other than the original injuries to the children.

A two month old girl was thrown against the wall by her father and suffered a severe head injury. She was found to have a partially healed greenstick fracture of the femur when apprehended, indicating that she had been physically abused prior to the final incident. The child died in the care of M.S.S. at the age of twenty months from a seizure caused by the original head injury.

A fifteen month old girl was beaten and shaken by the mother’s common-law husband. She suffered a fractured skull and massive head injuries. The medical examination revealed that the child had been previously physically abused. She was apprehended by the M.S.S., made a permanent ward and died of seizures related to the head injury nine months later.

Twenty of the 25 children who suffered prior abuse and neglect were never in the care of the M.S.S..

The Coroner’s files were examined to determine if child welfare investigations had been conducted with regards to incidents that occurred prior to the incident that caused the death. Of the 25 children who were abused and/or neglected prior to the incident that caused their death child welfare investigations had been conducted in 14 of the cases. The concerns in these cases appear to have been reported by persons outside of the home.
In 11 of the cases no report was made of risk to the child. There was no contact between the M.S.S. and the children prior to their deaths.

**Perpetrators**

The data gathered from the B.C. Coroners Service was compared to other studies of perpetrators. Table 10 provides a comparison of the findings.

<table>
<thead>
<tr>
<th>Study</th>
<th>Number of Deaths</th>
<th>Perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adelson</td>
<td>46</td>
<td>78% Parent</td>
</tr>
<tr>
<td>Resnick</td>
<td>131</td>
<td>67% Mother: 33 % Father</td>
</tr>
<tr>
<td>Kaplun and Reich</td>
<td>112</td>
<td>Majority by Mother</td>
</tr>
<tr>
<td>Daly and Wilson</td>
<td>158</td>
<td>93% Parents</td>
</tr>
<tr>
<td>Stats Canada (Begin)</td>
<td>542</td>
<td>69% Parent or Substitute</td>
</tr>
<tr>
<td>Silverman and Kennedy</td>
<td>620</td>
<td>52 % Mother: 48% Father</td>
</tr>
<tr>
<td>Greenland</td>
<td>100</td>
<td>91% Parents</td>
</tr>
<tr>
<td>Present Study</td>
<td>35</td>
<td>74% Parent or Substitute</td>
</tr>
</tbody>
</table>

The studies clearly found that parents, or those in the role of the parent, pose the greatest risk to children in instances of child abuse and/or neglect. The B.C. Coroners Service data used in the present study supported the finding that children are most at risk of being killed by a parent or parent substitute.

Table 11 indicates who caused the death of the child for each year of the study.
Mothers were identified as having caused the greatest number of deaths, followed by fathers. Men who were in the role of step-father, and non-related males not living in the home, accounted for an equal number of deaths. A perpetrator was not identified in 5 of the deaths, although the mother was clearly suspected in 3, the father in 1 and in 1 case the perpetrator was not determined.

Of the 35 deaths in this study parents or parent substitutes were found responsible for the death in 26 of the cases. Although mothers appear to have been responsible for largest number of deaths, when men in step-parent roles are added to the natural fathers the total for men in the role of the father increases to 15. Of the 5 deaths in which the perpetrator was classified as undetermined the mother was clearly the suspect in 3 and the father in 1. Mothers are thus suspected of causing a total of 15 deaths, fathers 11 and men in the role of the step-father 4. The total number of deaths apparently caused by parents or those in a parental role is 30.

Of the 4 deaths caused by unrelated males the man lived in the home in one of the cases as a boarder. (The man cared for the children while the mother worked
and socialized, but he claimed that he was not in a relationship with the mother). In one case the unrelated male was not known to the child and her family. The child was with a friend at the friend’s mother’s when the mother’s common-law killed both of them. One child was killed by a friend of the parents during a sexual assault after he and the parents had been drinking heavily. One child was killed by an unrelated teenage boy from the community who was known to the family.

**Cause of Death by Age of the Victim**

The ages of the children killed were examined to determine if any age range is more at risk of dying from a particular form of assault.

Table 12 examines the cause of death and the age of the victim.

**Table 12: Cause of Death by Age of Victim**

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt; 5 Years</th>
<th>6 - 11 Years</th>
<th>≥ 12 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gunshot</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Blows/Blunt Force</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Drowning</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Smother/Strangle</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Shaking</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Burning</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Undetermined</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>4</td>
<td>3</td>
<td>35</td>
</tr>
</tbody>
</table>
When the deaths are examined it becomes apparent that children aged 5 and under are vulnerable to all forms of assault and comprise eighty percent of the victims. Although children over the age of 5 account for deaths in all categories, with the exception of shaking, the numbers are greatly reduced. Deaths due to shaking were limited to children aged 5 and under. The disproportionate size and weight of the head of infants and small children places them at risk from shaking, whereas the risk is not as great to older children.

In two cases the cause of death was classified as undetermined. The victims were under the age of 2 in both cases.

The children often had no opportunity or ability to protect themselves. Children of all ages are defenceless against a gun. The oldest child shot was apparently not aware her father had a gun and thus she made no move to flee, the younger children did not have the means to escape.

Children who died from blows and blunt force were generally too small to defend themselves. The infants and small children were powerless to stop the adults from throwing them, or beating them. In one case two girls both aged twelve were beaten to death with a hammer while they slept affording them no opportunity to anticipate or avoid the blows.

Of the children drowned only one was over the age of 5. The children could not break away from the adult intent on holding them under the water.

The strength of adults is evident in the smothering and strangling of victims. The youngest 3 victims in this category aged 5 and under were smothered, the older victims aged 6 and 10 were strangled. They may have been able to fight off an adult
covering their mouth and nose, but were powerless against a ligature around the neck.

Three children aged 5 and under died of burns suffered from deliberately set fires they could not escape. The child in the 6 to 11 year old group who died in a fire was six years old.

**Cause of Death by Perpetrator**

The relationship between the cause of death and the perpetrator was examined to determine if there was any difference in how the perpetrators caused the death.

The data is illustrated in Table 13.

**Table 13: Cause of Death by Perpetrator**

<table>
<thead>
<tr>
<th></th>
<th>Mother</th>
<th>Father</th>
<th>Step-father</th>
<th>Unrelated Male</th>
<th>Undeter. Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gunshot</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Blows/Blunt Force</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Drowning</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Smother/Strangle</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Shaking</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Burning</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Undetermined</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>10</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>5</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

Fathers and step-fathers have been reported separately to illustrate the differences in how they killed. Seven children from 3 different families were shot by
their fathers who then committed suicide. Evidence presented at the inquests indicated that in each instance the mother had left the father and had taken, or was about to take, the children with her. The fathers were the only perpetrators to shoot their victims. No mothers killed the children and father as a reaction to the marriage or relationship ending. No step-fathers shot children, or killed the children in response to a relationship ending.

Mothers were the only perpetrators to kill children in every classification of death with the exception of gunshots. Based on the data mothers can not be considered to have used one method of killing their children to the exclusion of others. In two of the deaths the mothers were single parents raising the children on their own.

Unrelated males killed children by blows and blunt force, drowning and shaking. Of the four children killed by unrelated males three were sexually assaulted either prior to, or at the time of death.

**Perpetrator by Age of the Victim**

The perpetrators were examined by the age of the victim to determine if children of any particular age are at risk from an identifiable group of perpetrators. Table 14 illustrates the perpetrator by the age of the victim.

Children aged 5 represent the largest number of victims and they were killed by each classification of perpetrator. The high number of mothers and fathers causing the deaths is a reflection of the parents being the most represented group in
Table 14: Perpetrator By Age of Victim

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>&lt; 5 Years</th>
<th>6 - 11 Years</th>
<th>≥ 12 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Father</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Step-Father</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Unrelated Male</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Undetermined</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
<td><strong>4</strong></td>
<td><strong>3</strong></td>
<td><strong>35</strong></td>
</tr>
</tbody>
</table>

the study. Four of the five deaths in which the perpetrator was not identified involved children under that age of 2.

Data Sources Used By The Coroner

The files were examined to determine what data sources the Coroner used to conduct the inquest into the deaths of children. Particular attention was paid to whether or not the M.S.S. had been contacted at the time of the child’s death, or during the inquest process.

M.S.S. was clearly called by the police or Coroner in 21 (60%) of the cases. Of the remaining 14 (40%) cases when M.S.S. was apparently not called a review of the files indicates that children may have been at risk in 6 cases (for a total of 10 children between the families) and the risk was not assessed.

Coroners files contained police reports that were used in the inquest in 34 (97%) of the cases. A police report does not appear to have been done on one case
in which the cause of a fifteen month old child’s death was undetermined. The
inquest appears to have addressed the issue from a medical perspective.

The medical history, excluding hospital records, prior to the incident causing
death (doctor’s files, Public Health records) was checked in 22 (63%) of the cases.

The hospital records were checked in 15 (43%) of the cases, and not checked
for 20 in (57%) cases. Hospital records appear to have been used when the child
died in the hospital after resuscitation attempts failed. The records were used to
clarify that injuries were not inflicted during resuscitation attempts, to document the
nature of the injuries and response of the parent. Hospital records do not appear to
have been used to determine if the child had received prior medical attention for
possible abuse or neglect in every inquest.

Autopsy reports were used in all of the inquests.

Reports from psychologists, psychiatrists, pathologists, fire and ambulance
crews, and in one instance, the telephone company, were used as appropriate by the
Coroner. Files of doctors, Public Health Nurses, the parole board, school and Mental
Health were used in some cases. The Coroner used news footage taken by a
television crew and reporter in one case where the media had been covering the
stand off between the police and the father before he killed his children.

M.S.S. Files

A check of the M.S.S. electronic file system revealed that of the total 35 cases
the M.S.S. had open Family Service files on 7 of the families at the time of the child’s
death. A total of 12 children died between the 7 families. In the deaths of two
children from 1 family the M.S.S. had a closed Family Service file. Five of the children (from 4 families) had been in the care of the M.S.S. and thus had closed Child In Care files.

When the Coroner’s files are compared to the M.S.S. electronic files it appears that the risk to other children in the home was not assessed in 6 of the 35 cases as the M.S.S. was not called by the police or the Coroner. A total of 10 children were left in homes without the risk to them being assessed.

In one case an infant died of a ruptured stomach and was found to be severely malnourished, three siblings were in the home. A three year old girl was beaten and shaken to death, the M.S.S. was not notified of the death or the three siblings in the home. In two instances there was clearly alcohol related neglect that contributed to the deaths of children, the risk to the surviving child in each family was not assessed. One case involved a child who appeared to have been neglected prior to being shaken to death, there was no assessment of the risk to his four year old brother. A sixteen month old boy died in unexplained circumstances with bruises found on his face, the M.S.S. was not notified of the death, or concerns raised by the emergency personnel of the mother’s lack of response to the death.

In two instances the inquest found that M.S.S. had not followed up on the reported risk to a child. A doctor wrote to the District Office of the M.S.S. expressing his concern for a three year old girl. No investigation appears to have been conducted and the child was shaken and beaten to death a week later.

A report was made by a hospital social worker that the doctor was concerned that a three month old girl was malnourished and diagnosed as failure to thrive. The
M.S.S. social worker gave the hospital social worker a "glowing" account of the family based on inquiries made by the parents prior to the child’s birth with regards to placing her for adoption. No investigation into the doctor’s concerns was conducted. The child died of a ruptured stomach and was found to be severely malnourished at the age of seven months.

**Poverty**

The attempt to determine the rate of poverty in the families of the children who were killed was limited. Whether or not the family had received Income Assistance was the only measure available to assess poverty.

Thirteen of the deaths were in families on Income Assistance at the time of the death, one family had received Income Assistance in the year prior to the death. The 14 cases represented 40% of the victims. The rate of poverty may have been higher but it was not possible to determine this accurately from the information in the Coroners files.

**Neglect**

Seven deaths had clear documentation of prior neglect. The children in 86/01 and 86/02 had been previously apprehended to the alcohol and drug related neglect on the part of their parents. The children were shot to death by the father. In 87/06 a three year old girl was sexually assaulted by an adult male who had been drinking heavily with the parents prior to her death. The parents were unconscious from the consumption of alcohol when the child was taken from the home and killed. Alcohol
related neglect of the deceased and her two siblings was brought out in evidence at the inquest. There had been no involvement by the M.S.S. with the family prior to, or after the death. A seven month old girl was starved and died of a ruptured stomach from trauma in 87/07. M.S.S. had been involved prior to the child’s birth as the parents had considered placing her for adoption. A call had been made to M.S.S. when the child was three months old as she had been seen at the hospital and diagnosed as failure to thrive. No action was taken by M.S.S. Alcohol related neglect was a factor in the death of a three year old Native girl in 87/09. The mother had a history of alcoholism and multiple partners. Death occurred when the child was sexually assaulted with a broom handle and rapted by the mother’s common-law husband. There was no involvement by M.S.S. prior to, or after the child’s death. A ten year old boy was strangled by his mother within three months of having been returned home by the M.S.S. The mother had a history of psychiatric problems and a history of neglecting the deceased and his twelve year old brother. In 89/06 the child was not fed and was described as "severely malnourished" after dying of drowning. She had been apprehended by the M.S.S. and returned home under an interim supervision order the court a month later. The child died three and a half months later.

Deaths of children who had been neglected account for 7 of the 35. Of the 7 deaths there was alcohol related neglect in 2 deaths, while there was alcohol and drug related neglect in 2 other deaths. Substance abuse was thus a factor in the neglect of 4 of the 7 neglect deaths, and 4 of the total 35 deaths.
Native Children as Victims

One third of the children in care in B.C. are Native, yet Native people make up only 3.5% of the general population. In this study 4 children were clearly identified as being Native by the Coroner. Death 87/05 involved teenage Native parents. The father was caring for their only child, a two month old boy, when he became frustrated by the child’s cries and shook him. It was revealed at the autopsy that the child had a recent bruise on his thigh and had been also been shaken at one point in the preceding ten days. The father had a history of alcoholism and was described as "violent." No prior involvement appears to have occurred on the part of the M.S.S. The father was convicted of manslaughter in Youth Court.

A three year old girl was raped and sexually assaulted with a broom handle by her mother’s common-law husband in 87/09. Death was caused by asphyxia of the chest as the child’s body was compressed by the perpetrator during the assault. The mother and her common-law husband were described as "very heavy drinkers" at the inquest. It is not clear how long the common-law husband had lived with the family as the mother is described as having "multiple" partners. There had been no prior involvement by the M.S.S. The common-law husband was found guilty of first degree murder.

In 88/07 a six year old girl was drowned and raped by an unrelated teenage Native male on a reserve. The girl lived with her grandparents. The teen was charged and convicted of first degree murder in Youth Court.

Death in 88/10 occurred when the mother was repeatedly kicked in the stomach by the father in an attempt to kill the almost full term fetus. The viable fetus
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(had he not been injured he would have lived) died of injuries to the chest, brain and right lung. He was delivered two days after dying with a blood alcohol content of .18 (.08 is legal impairment). Both parents were described as alcohol and drug addicts living on the streets. The father was charged with assault causing bodily harm, the outcome is not noted on the Coroner’s file.

Three of the four deaths of Native children involved substance abuse by the parents.

Sexual Abuse

Five girls were sexually abuse prior to, or after death. Two twelve year old girls (87/03 and 87/04) were killed with hammer blows and sexually assaulted either at the time, or just after death. The perpetrator was the common-law husband of the mother 87/03. The mother was killed prior to the girls. The perpetrator committed suicide after confessing to the killings. A three year old Native girl was raped and drowned by an unrelated male who had been drinking heavily with her parents the night before her death. The parents were in the home and unconscious from the consumption of alcohol at the time of the death. The perpetrator was found guilty of first degree murder. A three year old girl was raped and sexually assaulted with a broom handle by her mother’s common-law husband. The mother was unconscious from the consumption of alcohol at the time of the assault. The perpetrator was found guilty of first degree murder. Case 88/07 involved the drowning and rape of a Native six year old girl by an unrelated Native teenage boy on a reserve. He was found guilty of first degree murder in Youth Court.
Criminal Charges

Criminal charges laid and the outcome of the legal proceedings were noted in each case.

Criminal charges were not noted on all of the Coroners files. Some files noted that charges had been laid, but did not include the outcome of the trial, others included both the charge laid and the outcome. The number of charges that were laid was influenced by 11 of the 35 cases in which the perpetrator committed suicide immediately after killing the child, or children. Fathers were responsible for 7 deaths and mothers for 4.

An unrelated male committed suicide after confessing to the murders of 2 twelve year old girls and the mother of one of the girls. He had been charged with 3 counts of first degree murder prior to his suicide, 2 of which concerned the girls killed.

Charges were laid in 14 of the remaining cases. Five mothers (one killed two children), three fathers, two common-law husbands of mothers and three unrelated males were charged. No charges were laid in eight deaths, generally for a lack of evidence.

Convictions were obtained in three charges of first degree murder. Unrelated males were convicted in two cases, and the mother’s common-law husband in the third. A conviction of second degree murder was obtained against a mother, and against the mother’s common-law husband in a different case. One father was convicted of assault (the child died 18 months after the injury and by law the father
could not be held responsible for her death as she died more than 12 months after the injury). One mother was convicted of manslaughter.

One unrelated male was acquitted of manslaughter and assault causing bodily harm. The outcome of the criminal proceedings was not noted on six files.

Case Studies

Case #1

The inquest is an example of a case in which the cause of death and perpetrator are known, but, the circumstances leading up to the deaths raised questions. The inquest dealt with the deaths of the children identified as file numbers 86/04 to 86/07.

A phone call was made to the police by the mother on September 10, 1986 to report that her estranged husband had held her captive all night, beaten and sexually assaulted her and had left the home with their four small children. The father was armed and had a history of violence, including assault of the mother. The mother had left the husband three weeks earlier, leaving the children in his care. She returned to the house on the evening of Sept. 9th. to discuss the living arrangements of the children with the father. He responded by terrorizing the mother all night. When he left the home in the morning with the children he told the mother that if she called the police he would kill the children. After escaping to the neighbours the mother called the police.

Police responded in unmarked vehicles and attempted to intercept the father before he returned to the home. They were not able to do so and the father entered
the home with the children. While the police were attempting to establish phone contact with the father to facilitate the safe release of the children fire broke out in the house. Fire fighters entered the home and found the father and four children aged 11 months, 5, 4, and 2 years dead from gunshot wounds to the head.

Issues addressed at the inquest included whether the risk to the children had been known beforehand and if the deaths could have been prevented. A forensic psychiatric profile of the father was completed at the Coroner's request. Twenty-five witnesses testified at the inquest.

Testimony was heard from the mother, a friend of hers, the father's adult son, the father's friend and a former employer. The professionals who testified included the forensic pathologist who conducted the autopsies, a forensic psychiatrist, the M.S.S. social worker who provided services to the family, the family doctor, RCMP officers and dispatchers involved in the incident, the teacher of the child who attended school, ambulance attendants, fire fighters, the fire chief and a fire protection specialist. Evidence was given by people who had been involved in the incident. These included the neighbour, two television camera operators who had been monitoring and filming the event, and a reporter. The news footage taken by the camera operators was entered as an exhibit at the inquest.

A forensic psychiatrist testified that the risk to the children was "unpredictable" and the preventative actions had been appropriate. It was concluded at the inquest that the services provided to the family prior to the incident had been appropriate, the father had not been considered to be a risk to the children and that little could have been done to foresee his actions. The jury reached the conclusion that the father
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appeared to have killed the children in a final act of control as he realized that his wife was not going to return to him.

The deaths were listed as homicides, and the perpetrator identified as the natural father.

Case #2

The inquest is an example of a case in which prior abuse was suspected, the cause of death was clear, but how the death had occurred raised questions. Despite a very complete police investigation and inquest charges were not laid against the suspected perpetrator. The inquest identified dealt with the death of the 5 year old boy identified in case number 86/08.

The adoptive parents of a five year old boy (he was within three weeks of his sixth birthday) called the ambulance on the evening of May 18, 1986. It was reported that the child had drowned while playing alone in the bath tub. After receiving initial treatment at the home and local hospital the child was transported to Children’s Hospital. Efforts to resuscitate the child were not successful.

Bruises were noted on the child’s forehead, chin, right eye brow and scalp by the hospital staff. A forensic pathologist determined that the bruises were inflicted in the six hours preceding death. Drowning was listed as the medical cause of death. During the investigative process several calls were made by the adoptive parents to the pathologists to find out the results of the autopsy. No calls were made to the police officer conducting the investigation.
When told that the child had drowned the adoptive mother stated that she was "sure" he had not. She questioned the pathologist about the findings concerning the cause of death and stated "You know was somebody out on a binge the night before and didn’t do the autopsy right?" The adoptive mother claimed that "something" made the child unconscious and thus he drowned. Later in the investigation she stated that the child had a seizure causing him to drown, but no medical evidence or history of seizures was found.

An inquest was held to determine how the child had drowned and how he had been bruised prior to his death.

The child had been apprehended when in the care of his natural mother on the grounds of neglect, including malnourishment. He was placed for adoption privately by the mother at the age of three. The couple who adopted him had an older adopted daughter already in the home.

A delay in finalizing the adoption was requested by the adoptive parents in the fall of 1985. They stated to a M.S.S. social worker that they were not sure they wanted to complete the adoption due to the child’s "behavioral problems." The behavioral problems were assumed to stem from the neglect the child had suffered while in the care of his natural mother.

The adoptive parents described the child as hyperactive, a compulsive eater, "very good or very bad" and difficult to discipline. The child was described as having a "negative" relationship with the adoptive mother.

Services were being provided to the child by a school psychologist. The psychologist noted that the adoptive parents came to the school to tell him the child
had died. He testified that they displayed a lack of emotion when speaking of the child's death.

Evidence was presented that the child had a bruise on his forehead between his eyes in October of 1985. When asked what had happened the adoptive mother told the teacher that the child had said that a piece of wood fell and hit him. The teacher does not appear to have asked the child directly how he had received the bruise. Three cuts were seen on the child's head in December of 1985. Testimony was heard from the teacher that the child had stated to her that he had been hit on the head with a potato masher by the adoptive mother. No report was made to the M.S.S. despite the child's clear statement that he had been hurt by the adoptive mother. In April of 1986 the child had a bruise to his right eye, and in September of 1986 his mouth was bloody. The school apparently accepted the explanation of the adoptive mother that the child was hurting himself as he was "disturbed."

Evidence was presented that a neighbour had reported bruises on the child to the Public Health Nurse. A report was not made by the Public Health Nurse as she noted that the family "does not like any involvement by M.H.R." (the previous name of the M.S.S. was the Ministry of Human Resources).

During the police investigation the investigating officer interviewed a broad range of people with knowledge of the child. Interviews were conducted with the adoptive mother and father, natural mother, M.S.S. social worker, teacher, school psychologist, adoptive mother's former husband, neighbours and ambulance attendants. The officer interviewed the pathologist, hospital staff who had attempted to resuscitate the child and neighbours. A request was made of the adoptive parents
to take a polygraph test, they refused to do so. While adoptive mother was clearly a suspect, the adoptive father appeared to be protective of her in the information he provided to the police. It is not clear if the M.S.S. was involved in the actual investigative process. A variety of explanations were offered by the adoptive mother as to how the child had been injured on previous occasions, and why she could not be responsible for his death. She stated that as she had diabetes her hands were so weak that she could not hold him still to spank him and thus hit him wherever the blows landed. The adoptive mother stated that due to her poor eye sight she would not know if the child was cut. She further claimed that because of her poor eye sight she did not know how deep the water was in the bath she ran for the child on the night of his death. The adoptive mother stated that the child would injure himself deliberately, played "rough," lied a great deal, and did not like women. She could not explain her earlier claim that she had called the ambulance before knowing the child had drowned. At one point she stated that perhaps the adoptive father had "shaken" the child, but she was "not sure." When asked how the child’s face was bruised the adoptive mother stated "Maybe he fell in his bedroom."

All information sources available including the child’s medical files, and the records from Children’s Hospital were utilized by the Coroner. Expert witnesses were called to give evidence about the bruises to the child’s face. The inquest attempted to address the question of whether or not the bruises could have been inflicted during the attempts to resuscitate the child. Experts expressed the opinion that the bruises appeared to be due to child abuse.
No determination was made at the inquest as to who was responsible for the child's death. The adoptive parents maintained their claim that he was alone in the bathroom and drowned, despite evidence presented that it is "very rare" for a child over the age of eighteen months to drown in the bath tub. The adoptive father continued to support the adoptive mother's explanations as to how she could not have caused the child's death.

A finding of undetermined was returned by the jury. No assessment of the potential risk to the seven year old sister in the home appears to have been done by the M.S.S. She remained in the care of the adoptive parents.

Case #3

The inquest is an example of a case in which the prior risk to the child was known and the M.S.S. was identified as not responding appropriately. Concern was raised during the inquest that the police investigation may have compromised the outcome of the case. No charges were laid against the suspected perpetrator. Issues with regards to the work of the M.S.S., police, and doctor were identified at the inquest.

The inquest dealt with the death of the child identified as file number 87/07. An ambulance was called for by the parents of a seven month old girl on February 3, 1987. It was reported that the child had died of unknown causes while in the home. The child was severely malnourished and weighed 6.7 pounds at the time of her death. During the autopsy the child's stomach was found to be ruptured due to "trauma." A pathologist expressed the opinion that the injury had occurred when the
child was placed over an adult's knee and spanked causing pressure on the stomach. The child had been injured four to five hours before her death.

She was the fourth child born to a twenty-two year old mother and a twenty-seven year old father who were on Income Assistance. The pregnancy had been unplanned. The parents were described by the family doctor as not "overly intelligent."

M.S.S. had been contacted by the parents prior to the child's birth as they had considered placing her for adoption. When born two months premature the child weighed 3.5 pounds. She was discharged from the hospital weighing 6 pounds to the parent's care as they had decided to not place her for adoption.

The child was taken to the hospital by an adult babysitter at the age of three months. She was admitted as she was severely underweight at six pounds. In the ten days the child was in the hospital she gained one pound, the doctors ruled out any medical cause for her not gaining weight. A diagnosis of failure to thrive was made. A report was made by the doctor to the M.S.S. that the child appeared to have not been fed, and that she was diagnosed as failure to thrive. A M.S.S. social worker gave a "glowing" account of the parents to the hospital social worker. No intervention or investigation occurred on the part of M.S.S. and the hospital released the child to the parents.

Criticism was levelled at the M.S.S. during the inquest as the social worker had not seen the child or the parents, or conducted any form of an investigation. The social worker appeared to not understand the implications of a child weighing six pounds at the age of six months, or what "failure to thrive" implied as far as the care
the child was receiving. Multiple sources of stress in the family were not assessed by the social worker (young parents who may have been mentally handicapped to a degree, four children, limited and low income, the child was unplanned and premature). At the time of her death in February 1987 the child weighed less than she had when discharged from the hospital in October of 1986.

The inquest was critical of M.S.S. for not reporting the concerns of the child being failure to thrive to Public Health so a nurse could monitor the case. The inquest was also critical of the doctor and hospital for not referring the case to Public Health. Evidence was heard that the doctor's office had received a call from the mother in October, 1987. The father was heard yelling and swearing at the mother to hang up the phone, the mother was told to by the nurse to call back and make an appointment for the child. No appointment was ever made and the doctor's office did not report any concerns at this time to M.S.S..

The inquest found that the police investigation was conducted by a "young and inexperienced" police officer. No interviews of the parents were conducted until three days after the child’s death. In the interim the parents had been told the cause of death as the Coroner could no longer delay telling the parents while waiting for the police to begin the investigation. The police investigation was not completed until March 13, 1987.

Testimony was heard as to how the parents responded to the police interviews. The father was described as "avoiding eye contact" and appearing to be "very nervous." The mother was described as "smiling, happy and cooperative." A statement was made by the mother that the child had "never" been readmitted to the
hospital after birth. No explanation was provided by the parents as to how the child was injured. The father was clearly suspected of having caused the injury, but no charges were laid.

M.S.S. was not told of the death by the police. There was no risk assessment with regards to the three surviving children in the home. The mother gave birth to a fifth child in December of 1987. (The M.S.S. electronic file system indicates that at some point after the inquest the M.S.S. opened a Family Service file.)

The death was listed as undetermined. A recommendation was made by the jury that the hospital establish guidelines as to when cases would be referred to Public Health, the recommendation was followed.

Case # 4

The inquest is an example of the police work and the inquest not addressing all of the concerns and possible sources of information that arose from the death of a child. The death is identified as inquest number 87/11.

An ambulance was called for by the mother of an sixteen month old boy, she reported that the child was unconscious. Ambulance personnel and fire fighters attending the home noted that the mother took several minutes to unlock the door to admit them. She reported that the child had been "down" (unconscious) for "two minutes" and was described as not displaying the emotions usually seen in such circumstances.

The mother was on the main floor of the house while the deceased child and his three year old brother were in a downstairs bedroom that was locked from the
outside. The deceased child was cyanotic and his skin cold. Efforts to revive him failed. Ambulance personnel noted that the child had bruises to the left side of his forehead described as two parallel lines 1/4 to 1/8th. inch apart. The marks extended from the hair line to the eye. He also had a 2 cm. spot on his forehead in the middle of his hair line where the hair appeared to have been rubbed away.

When asked how the child was bruised the mother stated that he "butts" his head against the wall or door if he wakes up to "fall back to sleep."

Although the mother had moved to the neighbourhood six months earlier she stated that she knew no one. The father was serving overseas in the Armed Forces leaving her to parent the two children on her own.

The mother told investigators that the boys slept in the basement bedroom despite there being two bedrooms on the main floor. She stated that the dampness of the basement helped their croup. The mother stated that she had put the children to bed at 8 pm. the night before. At 9 pm. she had checked on the children and upon finding the younger child on the floor put him back in bed. She then locked the bedroom door from the outside and went to bed. The mother stated that she could hear one of the boys breathing in the night due to the croup. "... had an awful rattle on their chest, you could hear it clear upstairs when one of them was breathing."

Despite the loud breathing the mother did not check on the children during the night. She got up at 8 am. and was "...um, just listening to them, wondering why everything was so quiet." The mother did not check on the children until 11 am. when she claims to have found the deceased child unconscious. She stated that it
was her normal practice to leave the children alone for that long. "Sometimes, sometimes he gets up in the morning and plays, then catches a nap."

No cause of death was revealed at the autopsy. A pathologist wrote in his report that "Marks on left forehead, linear, consistent with blow or fall."

Sources of potential information were not utilized by the police or the Coroner in this case. There is no record of the father of the children being interviewed to determine the relationship between the mother and children. Extended family members do not appear to have been interviewed about the mother's relationship with the children. Public Health, military or medical records do not appear to have been checked to see if the child had any prior medical condition that may have contributed to his death, or to assess whether there had been any previous abuse or neglect. Neighbours were not interviewed as to what they may have seen or heard. There is no record of M.S.S. in B.C. or other provinces the family had lived in being contacted to determine if there were previous child welfare concerns. (They were unknown to the B.C. system according to the M.S.S. electronic file system).

The mother does not appear to have been confronted on her response when the ambulance attended the home that the child was dead when she indicated he had been "down for two minutes," that the bedroom door was locked from the outside after she claimed to have found the child unconscious, and that the three year old had been left in the room with his dead brother while she went upstairs.

No report was made to the M.S.S. with regards to the circumstances of the death. There appears to have been no assessment to determine the safety of the three year old who remained in the home. The Coroner's file gave no indication that he
was interviewed by anyone as to what had happened to his brother, despite the boys being found together.

Many questions were left unanswered by the inquest. The death was listed as undetermined.
CHAPTER 4
DISCUSSION

The review of the B.C. Coroners files reveals an agency whose sole purpose is to determine why a person died. The existence of the Coroners system permits the investigation into the death to be undertaken in a neutral manner. Primary responsibility is to the deceased, not to the family, involved agencies, police or medical professionals who may assist in the inquest. This neutrality permits the Coroner to concentrate on the issue of why and how the person died.

The child abuse and neglect deaths investigated by the B.C. Coroners Service in the present study are similar to those seen in other studies using the Coroner's files as a data base. As with other studies parents, or parent substitutes were responsible for the majority of the deaths. The number of males and females was almost equal at 51% male and 49% female perpetrator. The finding is within the range found in other studies. Younger children were killed more often than older children in this study, 80% of the victims were aged five or younger. The finding was consistent with other research and emphasizes the vulnerability of small children. Small children can not leave a situation in which they are at risk, or physically protect themselves from the actions of an adult.

The Coroner's files provided evidence that 71% of the children had been abused or neglected in incidents unrelated to the incident causing death. The finding indicates the necessity of intervention if children are at risk. It is not possible to
predict how many of the children may have lived had appropriate services been in place, but the possibility can not be discounted.

That four children were returned to their parent's care in the months preceding their deaths by the M.S.S. raises concern as to how thoroughly the social worker had understood the risk factors present in the families and how completely the need for change had been addressed for the children to return home safely. There had been serious child welfare concerns in the families of all four of the children that had not been resolved to the point that the child's life was not in danger. One child was returned home under an interim supervision order by the court, raising concerns about the court's understanding of the risks children face in their families.

M.S.S. social workers are expected to deal with high risk families in stressful situations requiring a high level of skill and expertise. They have been provided with a matter of weeks of training, yet are expected to carry out complex investigations. Gil (1970) recognized that the lack of training for social workers makes it difficult for complete and complex investigations and assessments to be competed. Silverman (1978) recognized the need for training of not only social workers, but also other professionals who may be in a position to detect abuse and neglect; doctors, nurses, hospital staff and teachers. Straus et al (1981) recognized the need not only for training, but also for adequate staff and funding to respond to concerns "What is needed is a properly staffed, trained and funded child protection system"
Recommendation #1

It is recommended that the M.S.S. ensure that all social workers currently in the field are capable of assessing the risk to children.

Jaffe (1991) noted that "information given to the hospital, police or coroner by the parents or those who have been looking after the child is notoriously unreliable and usually attributes the injuries to the child's tendency to fall or to a variety of accidents." Information provided to the social worker can not be assumed to be any more reliable. Social workers need to be able to recognize a range from the subtle signs to deaths caused by abuse and neglect. The assessment of the risk to a child is complex requires "a multi disciplinary network" (Gil, 1970). Social workers must be able to work as part of an interdisciplinary investigation to ensure that the risk is adequately assessed.

Recommendation #2

It is recommended that in service training be provided for M.S.S. staff who are not adequately skilled in the assessment of risk to children.

The inquests revealed that seven of the 35 children had been neglected prior to their deaths. Two of the children were unknown to the M.S.S. Four of the seven children had previously been in the care of the M.S.S. prior to the incident causing death. Three were returned home by the M.S.S. and one was returned by the court under an interim supervision order. That the children had previously been in care
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raises concerns as to the understanding of social workers that neglect may be a symptom of greater problems in the home.

Recommendation #3

It is recommended that social workers receive training in working with neglectful families and in identifying additional risk to the children beyond the immediate issue of neglect.

M.S.S. is currently testing a three month model of training that would involve a new social worker spending three weeks in a classroom and nine weeks working along side an experienced social worker. The training is intended to provide social workers entering M.S.S. with a stronger base of training and skills to draw on. The current plan is to monitor the success of the training and possibly to extend it to all new employees entering the M.S.S. The needs of staff already in the field in addressing cases of neglect will not be addressed by the three month model of training.

Recommendation #4

It is recommended that the M.S.S. assess the training needs with regards to cases of neglect of the staff currently in the field and provide training as required.

Investigating the death, or near death of a child requires a level of skill and expertise most social workers have not had the opportunity to develop. Police forces
have officers trained as specialists to investigate serious crimes, including homicides. There is no corresponding team of highly trained social workers available to go anywhere in the province and conduct complex investigations. M.S.S. offices in the North where staff turn over is greatest would benefit greatly in having a pool of skilled and trained social workers to draw on in the event of a complex investigation. A team of child abuse consultants is being formed by the M.S.S. Consultants will be available to provide suggestions in child welfare investigations, but will not be conducting investigations. A team of skilled investigators would be able to work in conjunction with the local social workers and consultants to ensure that investigation was conducted as thoroughly as possible.

Recommendation #5

It is recommended that the M.S.S. develop a highly trained pool of social workers who would be available to respond to complex investigations, including deaths and near deaths, throughout the province.

The Family and Child Service Act is clear that the abuse or neglect of children must be reported to the M.S.S., yet reports were made in only 14 (56%) of the cases in the study. This raises the question of how effective the child welfare system is and if the reporting mechanism is understood. The high incidence of parents or other adults in the family who knew the child was being abused or neglected and did not call M.S.S. raises the question of how the M.S.S. is viewed. M.S.S. appears to have
been viewed as invasionary, rather than as an agency that could assist families to deal with the pressures they faced.

The high numbers of parents not reporting the abuse, or effectively protecting the child from the offending parent or caregiver raises concerns as to how safe some families are for children. Of even greater concern is that the risk to the remaining children in the home was not assessed by the M.S.S. in 6 families (for a total of 10 children) as no report was made.

An immediate report should have been made to the M.S.S. by the involved professionals.

The lack of reporting raises concerns over whether or not professionals dealing with the deaths of children understand child abuse and the potential risk to other children in the home, and conversely if they understand the need to report. Professionals need to be educated that if one child in the home has been killed, the risk to the others must be assessed.

**Recommendation #6**

It is recommended M.S.S. develop an ongoing program of education for professionals with regards to the need to report concerns that a child may have been abused or neglected. It is recommended that the education be provided to Coroners, medical staff, ambulance attendants, police, teachers and Public Health Nurses at a minimum.
When the perpetrators are examined it is clear that children are most at risk from parents and other caregivers acting in the role of a parent. The finding of this study that mothers are responsible for the greatest number of deaths is consistent with previous research. There is a higher number of fathers and step-fathers as perpetrators than in some studies. That one father killed four and a second father killed two children accounts for the higher than expected number in this category.

Parents and parent substitutes spend more time with small children than anyone else. The correlation between the age of the victims and who killed them reinforces that young children are most vulnerable to the very people who are expected to keep them safe. The consistent findings of researchers that children are most at risk from their caregivers reinforces the need for protection concerns to be reported and investigated.

The finding also reinforces the need for services to be available and accessible to a parent or caregiver. The parent must feel that they can request and receive services when struggling with family matters. It is unclear from the files if any of the families saw the M.S.S. as an agency that would assist them as the pressure in their lives increased. At least one family was noted by an involved professional to not want any involvement from the M.S.S. A second family clearly avoided the social worker and thwarted her efforts to supervise the child under a court order.

M.S.S. needs to be viewed as accessible by the community. The introduction of a social worker into a family should reduce their stress, not increase their anxiety if at all possible. Services offered by the M.S.S. have shifted in the last ten years from a more community based model of intervention, to a model focused on investigating
child abuse and neglect. Services to the families have generally been contracted to outside agencies and social workers have been afforded little opportunity to directly assist families in making positive changes in their lives.

M.S.S. will be working under the new Child, Family and Community Service Act as of January 29, 1996. The new legislation has a community based focus not found in the current Family and Child Service Act. The intent of the new Act is to involve extended family and community members, where appropriate, in providing support services to the family. The new Act, coupled with the planned move to a case management model of social work may cast the social workers in a more positive light in the eyes of the families and the community in general. Perhaps as social workers are viewed as part of a community effort to protect children families will be less reluctant to seek and receive services.

The Child, Family and Community Service Act provides for conditions to be attached to a supervision order. A clause can be included in the supervision order that should the conditions of the order not be met, or be broken, that M.S.S. must remove the child. Had such a condition been available under the Family and Child Service Act the social worker involved in case 89/06 may have been better equipped to protect the child.

The Child, Family and Community Service Act encourages the participation of appropriate community and family members in providing services for the family. The inclusion of extended family and the community in the process of identifying the family’s issues and determining a plan of intervention has the potential to broaden the resources to assist the family in meeting their own needs. A broader base of input
and services relieves the social worker of the current responsibility of often being the only one involved in attempting to meet the family's needs.

While the family and community should be involved in providing services to the family the M.S.S. must be clear in the mandate to protect children. The needs of the child must be the focus of the intervention as the child is the most vulnerable member of the family. Providing services to the parents and protecting the child are not mutually exclusive acts. The provision of services is a continuum, if the child can be safely maintained in the home with appropriate services, the services should be provided. In instances where the safety of the child is at risk the child must be removed and services provided to assist the parents in reaching a point where they can safely resume care of the child.

When acts of violence are committed against a child the full protection of the law must apply (Van Stolk, 1978). Child welfare legislation is intended to protect children, criminal law is intended to hold the offender accountable. Kempe (1987) raises the issue that if a child kills a parent it is called murder, but if a parent kills a child it generally results in a lesser charge. When children are injured or killed the same standard of accountability should be applied to the perpetrator as would be applied in the case of an adult harming an adult. Social workers see shocking examples of physical abuse dismissed by the courts as "discipline." Polansky (1975) stated that the physical abuse of children must be viewed as "an area in which social, medical and legal action must be authoritative, intrusive and insistent."
Schlesinger (1977) and Van Stolk (1978) note that the Criminal Code of Canada, Section 43, permits a parent or caregiver to use force in dealing with children.

Every school teacher, parent or person standing in the place of a parent is justified in using force by way of correction toward a pupil or child, as the case may be, who is under his care, if the force does not exceed what is reasonable under the circumstances (Criminal Code of Canada).

No section of the Criminal Code sanctions the use of force against an employee, spouse or any other person in a dependant relationship. The law sanctions the use of force against the most vulnerable and defenceless members of society. Van Stolk (1978) advocates for the repeal of Section 43.

Recommendation #7

It is recommended that the Criminal Code of Canada be amended and Section 43 repealed.

Recommendation #8

It is recommended that the police and Crown Counsel pursue criminal charges in cases of physical abuse of children.

Parents and caregivers who have harmed children need access to services to deal with their own issues that lead to the act of abuse. The removal of a child or children does not mean that the parent will not have more children, or be in contact with children from other families. To ensure that the risk to all children is minimized
as much as possible programs need to be available to parents to enable them to deal with their needs. The perpetrator who caused the death of the child in 89/05 by fracturing her skull was charged two years later with physical assault to a child from another family in which the child suffered rope burns to his neck.

The finding that 7 fathers shot and killed their children and then committed suicide after the mothers ended the relationship suggests that children may be even more vulnerable as a relationship ends. The shooting of the children appears to have been the final act of abuse and control of the woman by the man. Threats made by a man to kill his children to "punish" his wife for leaving him, or to get "revenge" so that she can not take the children with her must be taken seriously by those providing services to families. The data indicates that at least some men will follow through with their threats.

Recommendation #9

It is recommended that M.S.S. social workers, other professionals and services (transition houses, crises line volunteers and staff) who may be involved with women leaving abusive relationships be made aware of the risk this may pose to the children.

Recommendation #10

It is recommended that M.S.S. social workers be trained in the need to assure the safety of children when threats are made to kill the children.
The means of death are similar to those found in other studies. The means used to kill the children were intended to cause death in most of the cases (gunshots, blows, drowning, setting the child on fire, strangling, smothering). The perpetrator appears to have made a plan, however impulsive, to kill the child, and then carried it out. Shaking deaths, in particular, appear to have been the result of the person caring for the child becoming frustrated and acting impulsively. It must be noted though that the three children who died as the result of shaking had been shaken, or physically abused on more than one occasion according to medical evidence. What is not clear is whether or not the perpetrator meant to kill the child by shaking, or if they did not understand the degree of risk to the child.

Some of the deaths were clearly planned before hand with the parent gathering materials (guns, bullets, gasoline) in order to carry out the plan. In several cases the plan was carried out after access to the child or children had been arranged. Those investigating the deaths of children must realize that parents utilize a variety of means. If the deaths are not carefully investigated the intent to kill the child may not be recognized and the perpetrator could literally get away with murder.

Recommendation #11

It is recommended that Coroners, police officers, medical personnel and social workers receive training in recognizing child abuse and neglect deaths and the means used to kill children.
The Coroner is able to access information needed for the inquest, yet the one mandated body for dealing with child abuse was not called in 40% of the cases of apparent child abuse and neglect deaths. To obtain a complete picture of the child’s life all potential sources of information need to be accessed. The files of the M.S.S. may contain information that puts the child’s death in context.

Recommendation #12

It is recommended that the B.C. Coroners Service adopt a policy of checking the files of the M.S.S. in the deaths of children where any indication of neglect or abuse is present. The absence of a file by M.S.S. does not indicate the child was never abused or neglected and should not be assumed to mean so.

Recommendation #13

It is recommended M.S.S. social workers be trained as to the authority of the Coroner to request any files. Social workers need to provide a complete account of the dealings the M.S.S. has had with the family to assist the Coroner in determining how the child died.

Doctor’s, and public health records were not checked in over one third of the deaths. Hospital records were checked in less than half of the cases. When hospital records were checked it appears to have been to clarify the physical state of the child when admitted. The files appear to have been used to confirm suspicions of child abuse. The files may also provide valuable information on the health of the child, any
possible prior abuse or neglect and how attentive the parent was to the child’s need for medical care. In at least one case the medical records were used to provide evidence of the parent’s lack of emotion and apparent concern as their child died.

Recommendation #14

It is recommended that the Coroner adopt a policy of checking the health records in deaths in which child abuse and/or neglect may be a factor.

Care should to be taken that the files are accessed in every community the child has lived in, and from each professional who may have provided services to the child. Care should be taken to access not only the records of the deceased child, but also the other children who are, or who have been in the care of the parent or caregiver. The file of any child who has died should be carefully scrutinized to determine if there are any similarities with the death under investigation. Checking the files of the other children will assist in establishing if there is a pattern of abuse and neglect within the family.

The investigation conducted by the police was used by the Coroner in 97% of the inquests. The high percentage is an indication of the role the police play in investigating deaths and in providing evidence to the Coroner. Police reports appear to have been done from the stance of a homicide investigation, and not from the perspective of a child abuse investigation. Most of the investigations centred on the incident that caused the death and did not assess the potential of prior risk to the
child. Case 86/08 is a notable exception to this, with the police officer investigating the possibility of any prior abuse of the child.

**Recommendation #15**

It is recommended that police officers conducting investigations into the deaths of children receive training in the signs and symptoms of child abuse and neglect.

Training should include not only the physical indicators of abuse, but also the social and familial risk factors that may be associated with risk to a child. Investigations into the death of a child that may involve child abuse or neglect should be done in the context of the child’s life, and not focused only on the incident that caused death. Sergeant Glen McRae of the RCMP (interview, 1995) commented that for the police to carry out an effective investigation they require access to as much information as possible. M.S.S. is often viewed as an agency that does not share an adequate amount of information with the police.

**Recommendation #16**

It is recommended that the M.S.S. educate staff that the police may need to access information in the course of a criminal investigation. Cooperation between the police and the M.S.S. will assist in identifying the perpetrator ad the potential risk to other children in the home.
The B.C. Coroners Service currently provides concise and accurate information on child abuse to Coroners. Training for Coroners could be improved by the provision of expanded training on child abuse and neglect to guide Coroners in examining all aspects of the child’s life, and not simply the events preceding the death. The majority of Coroners in B.C. are lay people who do not have careers specializing in the investigation of death. Child abuse deaths require a degree of training and skill that most Coroners may not have had an opportunity to obtain. This was seen in inquest number 87/11 in which the police investigation and inquest left many unanswered questions as to how the child had died. Had the Coroner and police been more aware of the dynamics of child abuse they may have recognized the mother’s actions and statements as not fitting the circumstances of the death.

Recommendation #17

It is recommended that the Coroners in the B.C. Coroners Service receive training in the signs and symptoms of child abuse, and the investigative process of child abuse and neglect deaths.

The majority of the deaths in this study were investigated as incident specific homicides. The issue of prior abuse of the child does not appear to have been considered in most of the investigations. The focus on the specific incident that caused the child’s death appears to have lead to the death being classified as a homicide and thus the number of cases also noted as child abuse by the Coroner is lower than the actual incidents. The low number of recorded child abuse deaths may
lead to a misunderstanding of how many children die of abuse and neglect and the need for services to prevent further deaths.

At present it is extremely difficult to obtain figures on the numbers of children who die due to abuse and neglect. The Coroner does not have a separate listing for the deaths, the M.S.S. does not keep statistics on the deaths and a search of Vital Statistics reveals that deaths of children are rarely listed as being due to abuse or neglect. Unless verifiable figures on how many children have died are obtained it cannot be certain that the present interventions are targeted correctly or effectively.

Recommendation #18

It is recommended that the Coroner identify all child abuse and neglect deaths to ensure an accurate record is kept of the number of deaths.

The Coroner has the ability to call experts in any area to testify as to how a person met their death. A number of experts are consulted with by the B.C. Coroners Service on a regular basis. In child abuse and neglect cases consultation was held with the highly regarded child abuse team at Children’s Hospital. Additional expertise is available to the Coroner within the M.S.S., particularly in the steps taken in a child protection investigation. M.S.S. is in the process of developing child abuse specialists, these highly skilled social workers would be a valuable source of information for the Coroner. There are currently social workers who are very skilled in conducting complex investigations in the field.
Recommendation #19

It is recommended that the B.C. Coroners Service utilize the expertise in child protection investigations available in the M.S.S.

The Chief Coroner for B.C. is responsible for ensuring that agencies or Government Ministries receive recommendations made at an inquest. Inquests have been held into the deaths of children where M.S.S. was involved. While the recommendations were shared with upper management they were generally not shared with line staff who are responsible for providing services to families. The sharing of the information would ensure that staff are aware of the circumstances of the child’s death and the Coroner’s recommendations. This would provide social workers with an understanding of how the death may have been prevented and how they may need to alter their own practice.

Recommendation #20

It is recommended that the M.S.S. share the results of Coroner’s investigations in which the M.S.S. was involved with all social workers and district supervisors.

Neither the current M.S.S. policy nor the Inter-Ministry Child Abuse Handbook address the need for the Coroner to be notified of the death of a child when a child welfare investigation is being conducted, or when a child in care dies. The Family and Child Services Act makes no mention of notifying the Coroner, nor does the Family, Child and Community Services Act to be implemented in 1996.
Likewise the B.C. Coroners Act does not require that a report be made if the M.S.S. is involved with a child or family and the child dies. Current M.S.S. policy and practice of reporting the death to the police does not ensure that the Coroner is notified of the death, or that the death is recorded by the Coroner as a child abuse or neglect death.

Recommendation # 21

It is recommended that the Child, Family and Community Service Act be amended prior to implementation to make the reporting of child abuse and neglect deaths to the Coroner mandatory.

Recommendation #22

It is recommended that M.S.S. policy and the Inter-Ministry Child Abuse Handbook be rewritten (as is planned to reflect the implementation of the Child, Family and Community Services Act in January of 1996) to include the notification of the Coroner when M.S.S. takes part in the investigation of the death of a child.

The reporting of the death to the Coroner would ensure that an accurate account is made of child abuse and neglect deaths. An inquest or inquiry could be held by the Coroner should it be necessary to address any questions with regards to the child’s death. The reporting of the death to the Coroner would be a public acknowledgement by the M.S.S. that a public process is available to examine the circumstances of a child’s death. M.S.S. has a responsibility to satisfy the public that the work of the M.S.S. and other agencies and professionals is open to review when a
child dies. A role can be played by the B.C. Coroners Service in assuring the public that child abuse and neglect deaths are subject to review by an outside agency skilled in investigating death.

The recent public inquiry into the death of five year old Mathew Vaudriel by Judge Thomas Gove has heightened the public's awareness of child abuse deaths and the short comings of the current child protection system. The public is likely to continue to demand accountability from the M.S.S. when the needs of a child are not met and death occurs. The recommendations arising from inquests can provide an understanding of the need for services for children and families. The B.C. Coroners Service has the ability to alert the public and Government of the need to provide the services to ensure that children do not die of child abuse and neglect.

Summary of Recommendations

The following is a summary of the recommendations made:

1.) That the M.S.S. ensure that all social workers currently in the field are capable of assessing the risk to children.

2.) That in service training be provided for M.S.S. staff who are not adequately skilled in the assessment of risk to children.

3.) That social workers receive training in working with neglectful families and in identifying additional risk to the children beyond the immediate issue of neglect.

4.) That M.S.S. assess the training needs of the staff currently in the field and provide training as required.
5.) That M.S.S. develop a highly trained pool of social workers who would be available to respond to complex investigations, including deaths and near deaths, throughout the province.

6.) That M.S.S. develop an ongoing program of education for professionals with regards to the need to report concerns that a child may have been abused or neglected. It is recommended that the education be provided to Coroners, medical staff, ambulance attendants, police, teachers and Public Health Nurses at a minimum.

7.) That Section 43 of the Criminal Code of Canada be repealed.

8.) That the police and Crown Counsel pursue criminal charges in cases of physical abuse of children.

9.) That M.S.S. social workers, other professionals and services (transition houses, crises line volunteers and staff) who may be involved with women leaving abusive relationships be made aware of the risk this may pose to the children.

10.) That M.S.S. social workers be trained in the need to assure the safety of children when threats are made to kill children.

11.) That Coroners, police officers, medical personnel and social workers receive training in recognizing child abuse and neglect deaths and the means used to kill children.

12.) That the B.C. Coroners Service adopt a policy of checking the files of the M.S.S. in the deaths of children where any indication of neglect or abuse is present.
13.) That M.S.S. social workers be trained as to the authority of the Coroner to request any file.

14.) That the B.C. Coroners Service adopt a policy of checking the health records in deaths in which child abuse and/or neglect may be a factor.

15.) That police officers conducting investigations into the deaths of children receive training in the signs and symptoms of child abuse and neglect.

16.) That M.S.S. educate staff that the police may need to access information in the course of a criminal investigation.

17.) That the B.C. Coroners Service receive training in the signs and symptoms of child abuse, and the investigative process of child abuse and neglect deaths.

18.) That the B.C. Coroners Service identify all child abuse and neglect deaths to ensure an accurate record is kept of the number of deaths.

19.) That the B.C. Coroners Service utilize the expertise in child protection investigations available in the M.S.S.

20.) That the M.S.S. share the results of Coroner’s investigations in which the M.S.S. was involved with all social workers and district supervisors.

21.) That the Child, Family and Community Services Act be amended prior to implementation to make the reporting of child abuse and neglect deaths to the Coroner mandatory.

22.) That the M.S.S. policy and Inter-Ministry Child Abuse Handbook be rewritten to include the notification of the Coroner when M.S.S. takes part in the investigation of the death of a child.
Further Research

The Coroners files represent an area of under utilized data in the field of child protection. When combined with other sources of data the Coroners files can become an invaluable tool in assessing the extent of child abuse and neglect deaths. Cooper’s study, Wasted Lives. The Tragedy Of Homicide In the Family (1994) is an example of data from the B.C. Coroner’s files being used in conjunction with data from other sources. By comparing the deaths found in the Coroner’s files to those found in the files of the police, community mental health centres and forensic psychiatric files Cooper developed a detailed analysis of homicide in the family. Her methodology could be adapted to the research of child abuse deaths to determine the extent of the issue.

In using the files of the Coroner, police, and M.S.S. a more detailed analysis could be done of child abuse deaths in B.C. The study would be limited by the length of time police files are kept, unlike Coroner’s files which are kept for perpetuity, police files are destroyed after a period of time. (The RCMP recently reopened an investigation into the deaths of two small children in a remote area of B.C. As the police file had been disposed of years earlier the Coroner’s file was accessed for information and details of the deaths.) The inclusion of hospital records on fatalities of children would broaden the data base, but it may become so large as to become unmanageable in detecting cases of abuse and neglect.

An analysis of the training needs of social workers, police officers and Coroners in investigating possible child abuse and neglect deaths would be valuable to developing appropriate educational materials and training sessions.
Some jurisdictions have mandatory reporting of suspected child abuse and neglect deaths to the Coroner. It would be valuable to research how the number of deaths of children reported in these areas compares to the number reported in jurisdictions without such laws. The findings may assist in determining if mandatory reporting should be implemented in B.C.

A study of the B.C. Coroner’s files to assess child abuse deaths over a period of longer than the four years used in this study may provide further information on how many children die, how and at whose hands. The data would also assist in determining if child abuse and neglect deaths have been reported to, or detected by, the Coroner, in greater numbers at any particular time. Research would be valuable in the subject of men who kill their children as a result of their marriage or relationship ending. The findings could be used to protect children and their mothers from the ultimate expression of the father’s anger.

The investigation of the death of a child is extremely stressful for all persons involved. Constable Peter Backus of the RCMP investigated the death of a newborn child who had been smothered, dismembered and the body placed in a garbage bag. He commented that even while conducting the investigation and being aware of what had happened as a professional, "as a person you just don’t want to believe it."

During the investigation into the death of a two year old child I was told by the perpetrator how the child’s death had been caused. I was aware that despite my professional need to know how the child had died, I did not want to hear what had happened. After hearing the details of the death I was aware that I not only had to assist the parents in dealing with the child’s death, but also had to care for my own
needs. Debriefing is essential after conducting an investigation into a fatal case of child abuse or neglect.

Research into the impact of investigating child abuse deaths would be valuable to the social workers, police officers, medical personnel, Coroners and Crown Counsel who take on this task. In researching the impact on the professionals involved means may be found to lessen the impact of the death, or at least, in assisting professionals in dealing with critical incident stress associated with such an investigation.

The Coroner has played a role in the detection of child abuse and neglect deaths historically and in a current context. In learning from the Coroner social workers and other professionals have an opportunity to assist in protecting children from the ultimate form of child abuse and neglect.
REFERENCES


*Canada evidence act*

*Child, family and community services act*. (1994).


*Community, child and family services act*. (1994).


*Criminal Code of Canada*


Family and child service act (1980).


**Offence Act of British Columbia.**


APPENDIX A

Summary of Deaths

The following is a synopsis of each death and any recommendations made by the jury or Coroner during the course of the inquest.

86/01 and 86/02: A 12 year old girl and her 5 year old brother were shot and killed by the natural father while on a weekend visit to his home. The children had previously been in the care of the M.S.S. due to physical abuse and neglect concerns. An older half sister had been sexually abused by the father (her step-father). Both parents had long term addictions to alcohol and drugs. The children had been returned to the parents four months prior to their deaths. During the inquest the mother was described as "denying all responsibility" for the family dysfunction. She testified that the social worker and other professionals "should have known" that she was lying about her husband's drug use and violence.

The Coroner was critical of M.S.S. for having closed the Family Service file after the children were returned home with little follow up with the family. The Coroner commented on the lack of information sharing between agencies involved in providing services to the family.

A number of recommendations were made by the jury. It was recommended that when children are apprehended due to parental alcohol and drug addiction that M.S.S. provide counselling to the parents. The jury recommended that children be supervised for a minimum of three months when they are returned home to ensure that the issues that lead them being taken into care have been dealt with. A recommendation was made that parents with histories of drug and alcohol addiction be subject to medical examination on a regular basis to ensure that they are drug free and sober. The checking of the past medical and criminal histories of parents was recommended as a means of establishing if they are able to care for their children. As the case revealed difficulties in the sharing of information between agencies it was recommended that a system be established to ensure the exchange of information between agencies. The final recommendation was that mandatory reporting be implemented for transition houses when dealing with women who use their services due to violence in the home.

86/03: A three month old girl was shaken to death by her mother. The child had been sent to a relative's in India at the age of seven months and returned home one month prior to her death. She was taken to the community hospital by her parents on 86/10/17. The child was alleged to have fallen down the stairs. She had bruises to her body that the doctor did not record as suspicious, he did however note concern that the child had allegedly fallen down the stairs.

The child was taken to the hospital on 86/10/19 by her parents who stated that she had "collapsed" while playing. She was transported to Children's Hospital in Vancouver. It was noted by the medical transport team and the Children's Hospital...
staff that both parents demonstrated a lack of concern with regards to the child's critical condition. Multiple bruises of varying ages were found on the child's head, arms, abdomen, feet, and face. The bruises were not consistent with the explanation of the injury given by the parents. On 86/10/21 the child died. During the autopsy it was revealed that the child had been shaken and physically abused on more than one occasion. She was the size of an infant half her age and described as "pale." The death was described by the pathologist as "classic" shaken baby syndrome.

M.S.S. was not contacted to find out if there had been any previous concerns reported with regards to the family. There is no indication in the Coroner's file that the police or Coroner contacted M.S.S. to assess the potential risk to the other children in the home.

Criminal charges were laid against the mother, the outcome is not noted in the Coroner's file.

86/04, 86/05, 86/06 and 86/07: A 5 year old boy, 4 year old girl, 2 year old girl and 11 month old boy were shot and killed by their father who then lit the house on fire and committed suicide. The mother had left the father three weeks earlier and had returned to the home to discuss custody arrangements for the children. Over the course of the night the mother was repeatedly physically and sexually assaulted by the father. In the morning the oldest child was sent to school, the father then took the younger children with him to pick the child up. He told the mother that if she called the police he would kill the children.

After escaping from the house the mother called the police who attempted to arrive at the school before the father, but were not successful. As the police arrived at the home and attempted to establish contact with the father he shot and killed the children.

M.S.S. had an open file at the time of the death and the social worker testified at the inquest. Twenty-five witnesses gave testimony at the inquest, including a psychiatrist who conducted a forensic assessment of the father. After a detailed inquest it was found that the services to the family prior to the death had been appropriate as the risk by the father had been unknown.

86/08: A boy aged 5 years and 49 weeks drowned in the family bath tub. Despite a very thorough investigation by the police and clear concern that the adoptive mother had previously physically abused the child and caused his death no charges were ever laid. The inquest was not able to determine that bruises on the child's face had been present when the ambulance attended the home, and had not been inflicted during attempts to resuscitate the child. The adoptive father supported the adoptive mother in her claims that she had not harmed the boy prior to his death, or in the incident causing death.

A variety of explanations were offered by the adoptive mother for the bruises on the child's face and his drowning. Her explanation altered as investigators pointed out that it did not fit the physical evidence and circumstances of the death. She
claimed that she was too weak and blind due to diabetes to be able to hold the child
to hit him, that she was not able to tell how deep the water in the bathtub was, and
that the child had injured himself. When asked to explain why she phoned for an
ambulance allegedly prior to knowing that the child had drowned the adoptive
mother stated that the adoptive father may have shaken the boy. No evidence of
shaking was found during the autopsy. The adoptive parents phoned the pathologists
for the outcome of the autopsy on several occasions. Upon being told the boy had
drowned the adoptive mother questioned the competency of the pathologist and
disputed the findings.

The child had been placed for private adoption with the parents in May of
1984. He had been apprehended from his natural mother due to physical abuse.
Citing the child's behaviour as the reason the adoptive parents had expressed
reluctance to complete the adoption to a M.S.S. social worker in the fall of 1985.
Physical indicators and statements by the child that the adoptive mother had
physically abused him were not reported to M.S.S. by the teacher, neighbour and
Public Health Nurse. The Public Heath Nurse was aware that the adoptive mother
had a "negative" relationship with boy, that he had a pattern of "difficult behaviour"
and that he had been seen with bruises that did not fit the explanations given. A note
was made by the Public Health Nurse in her file that "The family does not like any
involvement from M.H.R." (previous name for M.S.S.). The Coroner noted that the
Public Health Nurse had "failed" the child in that she did not report the concerns of a
neighbour and her own observations that the child was being physically abused.

Multiple risk factors to the child were evident at the inquest. The death was
recorded as undetermined.

There were eight deaths in the 1986 Coroner's files that appear to have been
due to abuse and/or neglect.

87/01 and 87/02: A three year old boy and four year old girl were drowned
and stabbed by their mother. She had emigrated to Canada several years earlier and
married the father, an emigrant from a different country. During the inquest the father
indicated that he had been concerned about the mental health of the mother, but had
not acted on his concerns. He gave testimony that the children had attempted to tell
him that the mother "did bad things" to them. The father stated that he had not
understood the degree of risk to the children, that the mother had harmed, or would
harm the children.

When the father was at work the mother killed the children. He phoned her
from work and rushed home after becoming concerned about how she sounded. The
mother told the father that the children had gone "to a better place." His attempts to
revive the children were not successful. A note written by the mother indicated that
she may have been planning to commit suicide, but the father's arrival home
prevented her from doing so.

M.S.S. had no previous involvement with the family. Charges appear to have
been laid against the mother, but the outcome is not noted in the Coroner's file.
87/03 and 87/04: Two unrelated 12 year old girls were killed by hammer blows to the head and sexually assaulted either at the time of death, or shortly after death. The mother of one of the girls was living in a common-law relationship with the offender. The girl lived with her father and was visiting her mother. Her 12 year old girl friend had accompanied her for the weekend.

A fight began between the mother and her common-law as the mother did not want to have sex. The common-law husband beat her with a hammer and stabbed her. He then beat both girls to death with the hammer while they were sleeping.

The deaths were not discovered until the offender went to the police in a distant town the after the killings and turned himself in. He committed suicide two weeks later while incarcerated. The offender was on parole at the time for the 1971 murder of an eighteen year old woman. He was charged in 1986 with exposing himself to a female and was returned to prison for five months, during which he underwent psychiatric treatment.

No check appears to have been conducted to determine if M.S.S. had been involved with the family. M.S.S. had no prior involvement with regards to child welfare concerns with either of the girls.

87/05: A two month old Native boy was shaken to death by his 17 year old father who had been left to care for the infant for several hours on his own. The autopsy indicated the child had been shaken on at least one earlier occasion. A bruise that was less than twelve hours old was found on his right thigh "Shaken baby syndrome" was used in the Coroner's report to identify the death.

A letter had been written by the doctor to the M.S.S. one week prior to the death expressing concern for the child. The Coroner's file was not clear if the M.S.S. had acted on the doctor's concerns or not. No investigation by M.S.S. appears to have been commenced prior to the child's death.

Multiple risk factors were present in the family in that the parents were teenagers living in poverty, the father was the victim of violence as a child and was known to be violent and an alcoholic himself. He could not cope with the crying of his infant son and shook the baby. A charge of manslaughter was laid under the Young Offenders Act.

87/06: A three year old girl was raped and drowned by an adult male who was a long term friend of the parents. On the night the child disappeared from the family home the parents and the adult male had been drinking. Older siblings noted the child was not in the home when they awoke in the morning. The parents called the police when the siblings alerted them that the victim was missing. Several days after her disappearance the child's body was found in the river.

No check appear to have been done for M.S.S. files. M.S.S. does not appear to have been notified of the possible concerns to the other children in the home, despite the investigation clearly showing that the children suffered from alcohol
related neglect. Police and Coroner's inquiries appear to have centred on the incident that caused the child's death and no assessment was made of the risk to the other children.

A conviction of first degree murder was obtained against the perpetrator.

87/07: A 7 month old girl died after her stomach ruptured. A pathologist speculated that the injury likely occurred when the child was held over an adult's lap and "spanked." The blows to the child forced her stomach against the adult's knee. She was found to be severely malnourished, at 7 months of age she weighed 6.7 pounds.

M.S.S. had been approached by the parents with regards to placing the child for adoption shortly after her premature birth. Once the child was born the parents changed their minds and took her home. They had three older children, the oldest of whom was four years old at the time of the victim's birth.

A babysitter took the child to the hospital when the child was three months old as the child weighed six pounds. The doctor diagnosed the child as failure to thrive, M.S.S. was notified, but no investigation appears to have been conducted. A M.S.S. social worker gave the hospital social worker a "glowing" recommendation without seeing the child or assessing the situation.

Multiple risk factors were present in the family. The parents were aged 22 and 27, the child was the fourth in four years, the parents were described by the doctor as "low functioning," and had initially wanted to place the child for adoption. The child was diagnosed as failure to thrive, yet she gained weight while in the hospital and any medical cause for her low weight was ruled out. The parents did not keep medical appointments for the child and told the police that the child had never been hospitalized since her birth. The parents initially attributed the child's death to Sudden Infant Death Syndrome and offered no explanation when the injuries were discovered.

The father was suspected as having injured the child, but charges were never laid for lack of evidence. The Coroner was critical of the police investigation. The Coroner was also critical of the lack of involvement by M.S.S. in assessing the risk to the child when she was reported to be failing to thrive.

M.S.S. does not appear to have been notified of the child's death to determine the risk to the other children in the home.

87/08: A 2 1/2 year old boy was beaten to death by his mother's common-law husband. The child and his 7 year old brother had been apprehended by M.S.S. on Aug. 27/87 and returned home on Oct. 8/97. The older boy had been seen with bruises to his face during the seven months the common-law lived in the home.

The common-law claimed to have tripped while carrying the child up the stairs. He stated that he dropped the child and fell on top of him causing the injuries. It was noted by the pathologist that the child had been injured on at least four separate occasions and that the physical evidence indicated that child was a victim of
"child abuse." The common-law was tried and convicted of second degree murder. The older brother was apprehended and his natural father sought custody.

87/09: A three year old girl was raped and sexually assaulted with a broom handle by her mother's common-law husband. Death was caused by the compression of her chest during the rape. The mother, common-law and an adult male had been drinking heavily in the home the night before the assault. The victim was assaulted at approximately 10:00 am the next morning. Her eight year old brother found her near death in her bed and the police were called.

The common-law was convicted of first degree murder. M.S.S. had an open Family Service file dating back to 85/07/22. The mother had a history of heavy drinking and had lived with several different men. M.S.S. does not appear to have been notified of the death, or the risk to the eight year old brother assessed.

87/10: The body of a newborn baby girl was found when the contents of a storage locker were auctioned off for non-payment of storage fees. She had been delivered at home and smothered by a sock placed in her mouth. Fractures were found on both sides of her skull but it could not be determined if the fractures occurred during delivery or after the birth.

The mother had told no one she was pregnant and apparently concealed her pregnancy even from the child's father who was living with her. The victim was the third child of the mother.

In 1983 the mother was charged with concealing the body of her second child. The mother claimed that she gave birth at home and could not tie the infant's umbilical cord. She claimed that the infant bled to death and she hid the body. She was given a one year suspended sentence and was to receive psychiatric treatment. The mother gave no reason for having not sought medical treatment for either delivery.

The first child born to the mother had been placed for adoption at birth. Charges of second degree murder were laid against the mother in the death of her third child. A check was done by police of M.S.S. files during the investigation. M.S.S. had been involved with the mother when she was a child, but had no involvement at the time of the death of her second or third children.

87/11: A 16 month old boy died of undetermined, but highly suspicious causes, while in the care of his mother. The mother had been caring for the children on her own for the previous two and a half months as the father was overseas in the Armed Forces. The mother stated that she had put the victim and his 3 year old brother to bed in a basement bedroom at 8 pm on the night before his death. She checked on the boys at 9:00 pm. She stated that she could hear one of the children breathing from upstairs during the night as the boys had croup, yet she did not check on them again until 11:00 am. on the day of the death.
The mother phoned for an ambulance. It was noted by the ambulance crew that the front door was locked and that they had to wait for the mother to open the door. She stated the child had "been down" (unconscious) for "two minutes." The ambulance crew had to get the mother to unlock the lock on the outside of the bedroom the boys were in. The physical state of the child's body indicated that he had been unconscious for longer than the mother indicated. The mother claimed the child must have received a bruise on his forehead from "butting" his head against the wall or door to fall asleep. No clear cause of death was found, but the autopsy report noted that "Mark on left forehead, linear, consistent with blow or fall."

Neither the police or the Coroner checked M.S.S. for files. No interviews appear to have been done with possible sources of collateral information including the father, Public Health Nurse, extended family, the 3 year old boy who was present when his brother died, the family doctor or neighbours. The military records (as the father was in the Armed Forces) and medical history of the child and mother do not appear to have been checked. M.S.S. does not appear to have been notified of the child's death in undetermined circumstances with multiple risk factors present. The risk to the three year old brother does not appear to have been assessed by M.S.S..

There were eleven deaths in the 1987 Coroner's files that appear to have been due to abuse and/or neglect.

88/01: A six month old boy was shaken to death by an adult male border living in the home. The boarder babysat the infant and a four year old boy for the single parent mother while she worked and socialized. He stated that he was frustrated by the child's crying and shook him. The autopsy indicated that the child had been shaken on at least two previous occasions and had a laceration in the anal area.

The records of M.S.S. (open Income Assistance and Day Care files), Public Health and the family doctor do not appear to have been used in the investigation as the accused had confessed to shaking the child. No report appears to have been made to M.S.S. to assess the risk to the four year old child still in the home.

The boarder was charged with manslaughter and assault causing bodily harm. He was acquitted.

88/02: A two month old baby girl was thrown against the wall by her father as he could not cope with her crying. The child was apprehended by M.S.S., made a permanent ward and died 18 months later of seizures caused by the original injury. At the time of the apprehension the child was found to have a greenstick fracture of the femur in addition to the massive head injuries.

Files of the M.S.S., Public Health and the family doctor were not examined as the father confessed to injuring the child. The M.S.S. had opened a Family Service file twenty-three days after the child's birth.
The father was charged and convicted of assault. As the child died more than twelve months after the injuries were inflicted he could not be charged with causing her death.

The mother has since given birth to a girl in 1989 and a boy in 1990. The M.S.S. had a Family Service file open until 95/02.

88/03: A nine month old baby boy was shot and killed by his father who then committed suicide. The parents had separated shortly after the child's birth. The father had a history of alcohol and drug addiction, depression, was described as living a "reclusive" life style, had been threatening to commit suicide, told the child's mother he "hated" her, and wanted "revenge" as she had custody of the child. He had been drinking the day he picked the child up from the mother. When he did not return the child on time the mother assumed he was "punishing" her and did nothing. A friend of the father's went to visit him and found the child and father dead on the bed.

M.S.S. (open Income Assistance file) and other files (Public Health, medical, Mental Health) were not checked as the death was clearly a murder/suicide.

88/04: A 15 month old boy died of undetermined causes. The mother was home with the child and stated that she noticed that the child was having difficulty breathing. She checked on him, he "seemed to be o.k.," she checked again in forty-five minutes and found the child grey in colour with "minimal breathing." The child was transported to the hospital where he died.

The death raises concern as a sister had died at the age of four months allegedly of Sudden Infant Death Syndrome. Three other infants in the family (not clear in the file in this was the immediate or extended family) had died in the preceding ten years. The mother appeared to attribute the boy's death to S.I.D.S. even though he is too old to fit within the spectrum of S.I.D.S. deaths.

The investigation does not appear to have included checking for M.S.S. files (open Income Assistance file), Public Health files, the family doctor's records or the history of the children in the family who had died earlier. There was no police report on file and no indication that a police investigation had been conducted.

88/05 and 88/06: Boys aged 18 months and 3 years died of burns and asphyxiation after the mother doused them, their 5 year old sister and herself in gasoline and lit them on fire. The 5 year old girl survived and was treated for burns. She was apprehended and made a permanent ward.

The mother had been despondent over her husband's imminent release from prison. He had a history of physically abusing the mother and sexually abusing the children. Multiple services were in place and M.S.S. had been involved with the family for the previous two and a half years. A Family Service file was open at the
time of the deaths. The mother had not been considered to be at risk of committing suicide or of harming her children.

The police investigation and inquest were very complete and included all possible information sources.

88/07: A six year old girl was drowned and raped by an unrelated teenage male. The offender confessed, was charged and convicted of first degree murder in Youth Court.

88/08: A 3 month old baby girl died of head injuries. The autopsy revealed that the child had four skull fractures, a fractured humerus, multiple bruises to the scalp and that the injuries were inflicted "at least three days prior to death." The injuries had been inflicted at different times, indicating that the child had been assaulted on more than one occasion. The child had been born premature at thirty-one weeks gestation. She was hospitalized for two months after birth.

The mother initially gave a statement to the police that she had repeatedly thrown the child into the crib. She later claimed that her four year old daughter had caused the injuries and that she had confessed to "protect" the four year old. The mother was charged with manslaughter.

The Coroner's file does not indicate that M.S.S. files were checked for or that M.S.S. was notified of the child's death. The risk to the other children in the home does not appear to have been assessed by M.S.S..

88/09: A 10 year old boy was strangled by his mother. The victim and his older brother had been apprehended in Feb. of 1985 as the mother was committed for psychiatric treatment. The children were returned home in Feb. of 1986. The father was convicted of sexually abusing the boys in 1986 and incarcerated. The boys were apprehended in January of 1987 as the mother was again committed. She was then sent to jail on a shoplifting charge for four months. The children were returned to the mother's care in Feb. of 1988. In May of 1988 the mother called the police and claimed that an unknown male had entered the home and strangled the child. Physical evidence indicated that the mother had killed the child. The mother confessed and stated that she was frustrated by the child's bed wetting.

The mother had an extensive history of psychiatric problems. M.S.S. and Mental Health had long term involvement with the mother.

The Coroner's file is not clear if M.S.S. files were used in the inquest as the mother confessed to killing the child.

88/10: A viable male fetus of 30 to 32 weeks gestation was killed when the father beat the mother with the intent of causing the child's death. The fetus died of injuries to the right lung, chest and brain. A pathologist reported that any one of the injuries would have killed him. The mother was brought to the hospital after being
assaulted, the fetus was found to be dead, but the mother refused to stay to deliver. She returned to the hospital two and a half days later to give birth. The fetus had a blood alcohol content of 0.18%.

Both parents were alcohol and drug addicts who were known to have a violent relationship.

M.S.S. files were not checked. The parents had open Income Assistance files only. The police investigation appears to have been extensive. The father was charged with assault causing bodily harm.

There were ten deaths in the 1988 Coroner’s files that appear to have been due to abuse and/or neglect.

89/01: A 6 year old boy and a 4 year old girl were killed when the mother lit the family home on fire. She had an extensive psychiatric history and was undergoing treatment at the time of the deaths. The parents were attending marriage counselling. Police suspected that the mother set the house on fire in an attempt to kill the father and children. There were large insurance policies on the father and children. The mother had tried to get the father to drink milk before going to bed that contained the same anti-psychotic medicine prescribed for herself.

Three of the children were rescued from the fire by the father. He was not able to reach the two who died due to the flames and heat. In the confusion of the fire the mother put the surviving children into the family vehicle and drove to the airport. (She had fled the house with her purse and keys.) Police intercepted her as she was arranging a flight for herself and the children to her parent’s in Florida.

The investigators were of the opinion that the family knew more than they were willing to say. On the advice of their lawyer the parents would not give statements. The mother’s brother who was not in the community at the time of the fire was aware of information known only to the police and the person who had set the fire. He was not cooperative with the investigators.

M.S.S. was notified of the concerns for the safety of the surviving children immediately by the police. M.S.S. had been involved prior to and after the deaths. The police and Crown Counsel were continuing to gather evidence to possibly lay charges against the mother.

89/03 and 89/04: Boys aged 6 and 4 years were strangled by their mother. She stabbed the father, strangled the children and hung herself. The family had immigrated to Canada in July of 1987. The mother appears to have been socially isolated, and was described at the inquest as “quiet, often confused and appeared to be paranoid in many respects.” The mother had bought airline tickets for the children and herself to return to their country of origin one day prior to the deaths. She was described as appearing to be “depressed” at the time.

M.S.S. and other social agencies had not had contact with the family.
89/05: A 2 year old girl died of injuries suffered at the age of nine months (Dec. 1987) when the mother's common-law husband caused brain damage by fracturing the child's skull and shaking her. She died of seizures related to the massive brain damage suffered in the assault. The death certificate states that she was a "victim of physical abuse."

The mother had given birth to her first child at the age of 16. The child was 2 1/2 at the time the infant was assaulted. She had multiple partners and was described as "naive and immature." M.S.S. had an open Family Service file from May of 1986 and the mother was on Income Assistance.

The mother stated that the child had cried during the night, her common-law got up, she heard the child "choking.....gagging" but did not go check on the child. In the morning the child was found to be non-responsive due to massive brain damage.

Charges were not laid against the common-law due to a lack of evidence. The victim and her 2 1/2 year old sister were apprehended and placed with the maternal grandmother.

In May of 1989 the common-law was charged with physically assaulting the child of another woman he was involved with. The child suffered "rope type burns to his neck." The common-law told the police that he had "trouble" dealing with children.

He law drowned in Oct. of 1989 before he could be brought to trial.

89/06: An 11 1/2 month girl drowned. M.S.S. was involved within 6 weeks of the child’s birth due to concerns that the child was failure to thrive. The parents were known to avoid the "system," were described as dysfunctional and uncooperative with efforts to intervene to ensure the child’s safety. The mother was described as being low functioning, having a border line personality, immature, socially delayed and phobic. M.S.S. had an open Family Service file from 1986 due to concerns about the care of the oldest child, a boy, who was two years old at the time of the victim’s death.

A Public Health Nurse found that the victim was not gaining weight and was dehydrated during a home visit when the child was six weeks old. The mother was not feeding the child and resisted the efforts of the Public Health Nurse to be involved. The concerns were reported by the nurse to M.S.S.. Social workers apparently did not persist in trying to see the child after the mother denied them entry. The doctor admitted the child to hospital four days later and she gained weight. The child then returned home. The father took the child to the hospital when she was six months old. She was suffering from "severe malnutrition."

M.S.S. was requested to apprehend the child and did so when she was seven months old. The court returned the child under an interim supervision order until a hearing could be held six months later. It was outlined by the court that the child had to be seen at the hospital weekly. If one appointment was missed the parent's lawyer was to be called. If two appointments were missed M.S.S. was to be called and the
child apprehended. The child missed a month of appointments and M.S.S. was not called, and did not follow up to ensure the child was safe.

The After Hours office of M.S.S. was involved in investigating in the incident causing death. Police contacted M.S.S. when notified of the injury to the child.

On the day of the death the mother claimed that she left her two year old son and the victim in the bathtub while she answered the phone. When she returned to the bathroom the child had drowned. The police investigation showed that no call was made to the family home that evening. The child was found to be severely malnourished at the autopsy.

The court was critical of the professionals involved and the lack of interdisciplinary team work. Recommendations were made that the court hear all evidence when rescinding an apprehension; that M.S.S. ensure files are reviewed thoroughly when transferred between social workers and that the appropriate professional associations address the "lack of interdisciplinary team work" that occurred in this case.

Despite the mother being suspected of having drowned the child charges were not laid due to a lack of corroborating evidence. M.S.S. files were used in the very extensive inquest. M.S.S. continues to have an open Family Service file as the mother has given birth to two more children since the victim's death.

Six deaths were found in the Coroner's files in 1989 that appear to have been due to abuse and/or neglect.
# APPENDIX B

## Data Collection Sheet

<table>
<thead>
<tr>
<th>Name of child</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of parent:</td>
<td></td>
</tr>
<tr>
<td>D.O.B.</td>
<td>D.O.D.</td>
</tr>
<tr>
<td>Death listed:</td>
<td></td>
</tr>
<tr>
<td>Cause of death (actual):</td>
<td></td>
</tr>
<tr>
<td>Date of inquest:</td>
<td></td>
</tr>
<tr>
<td>Family information:</td>
<td>siblings?</td>
</tr>
<tr>
<td></td>
<td>marital status of custodial parent:</td>
</tr>
<tr>
<td></td>
<td>others in the home:</td>
</tr>
<tr>
<td></td>
<td>nonfamily caregivers:</td>
</tr>
</tbody>
</table>

Implicated as responsible for the death:

Basis for the implication?

Not implicated but suspicious?

Relation to the victim:

How long had they been in the child’s life?

Had they previously abused the child?

Did they live in the home with the victim?

Previous abuse: Yes: No: Undetermined:

Unreported but probable from autopsy:

Reported to MSS:

Files: Open: Closed:

Dates:

Open file at time of death:

MSS informed of death by Coroner: When:

MSS file examined by Coroner:

Listed as child abuse/neglect death:

Reasons the death may be suspicious:

Physical:

Social:

Familial:

Unanswered questions by inquest:

Gaps in information presented:

Police report:

Information Sources Not Utilized:

Treatment for death causing injuries:

immediate:

hospital:

clinic:
ambulance:
other:

How long after injury did the child die?

Did MSS investigate: Before death (due to another incident):
Before death (due to incident causing death):
After the death:

Child apprehended: prior to incident causing death
prior to death (incident)

Siblings Apprehended: prior to incident causing death of victim
prior to death (incident)

Child previously in care: Date returned:

In care at the time of death:

Who reported death or injury as suspicious:

Medical tests done prior to death (ie. Xrays, blood work, gas tests):

Documents or records used in the inquest:
  police report:
  MSS files:
  previous medical reports:
  hospital records:
  autopsy report:

Criminal charges:
laid:
against whom:
charge(s):
criminal trial held:
outcome:
no charges laid - why?

Did the assailant have a history of mental illness:

Who knew:
Previous treatment of mental illness:

Was risk to the child suspected prior to the death:
By whom:

Brief description of incident causing death as outlined in the Coroner's file:
APPENDIX C

Letter of Permission: B.C. Coroners Service
APPENDIX D

Letter of Permission: Ministry of Social Services