Release Date: December 22, 2006

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: ***THE FATALITY INQUIRIES ACT***

AND IN THE MATTER OF: JOHN ERIK DEMERY, DECEASED
(DATE OF DEATH: August 15, 2003)

Report on Inquest and Recommendations of
The Honourable Judge Fred H. Sandhu
Issued this 19th day of December 2006

APPEARANCES:

Ms. R. Malaviya, Provincial Counsel to the Inquest
Mr. I. Frost and Ms. J. Mann, for the Department of Family Services and Housing Directorate
Mr. T. Gutkin, for Child and Family Services General Authority and Mr. George MacDonald
Mr. J. Myers, for the Society for Manitobans with Disabilities
Mr. M. Thomson, for Winnipeg Child and Family Services
Ms. H. Van Iderstine, for Dr. Marilyn Raizen
Ms. M. Dzik and Ms. C. Tolton, for Winnipeg Regional Health Authority
Mr. A. Arenson, for the Parents

RELEASE DATE: December 22, 2006

M A N I T O B A

The Fatality Inquiries Act

Report by Provincial Judge on Inquest

Respecting the death of: John Erik Demery

An inquest respecting the said death having been held by me on May 31st-June 1st, 2005; June 8th-June 17th, 2005; December 14th, 2006; February 27th -March 2nd, 2006; April 3rd-April 13th, 2006; and June 26th, 2006 at Winnipeg, in Manitoba, I hereby report as follows.

The name of the deceased is **John Erik Demery.**

The deceased was born on April 18th, 2001 and was deceased on August 15th, 2003. The deceased came to his death, in his own residence, as a result of contracting bronchopneumonia. The manner of death was natural.

On August 15th, 2003 at approximately 2 p.m., the Winnipeg Emergency Response Service was called by the father of the deceased, Allan Demery, to report that he was at home with his son who was non-responsive. The ERS attended to find the child dead in his crib. John Erik Demery was pronounced dead at the scene. The Child Abuse Unit of the Winnipeg Police Service was called.

The deceased had been either a ward of Winnipeg Child and Family Services (CFS), or had been under voluntary placement, from birth until May 2003.

Attached hereto and forming part of my report is a schedule of all exhibits required to be filed by me.

DATED at the City of Winnipeg in Manitoba this 19th day of December 2006.

"original signed by:"
Fred Sandhu, P.J.

Copies to: Chief Medical Examiner (2)
Deputy Attorney General
Chief Judge, Provincial Court of Manitoba

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I. HOLDING OF INQUEST

Events of August 15, 2003

1. On August 15, 2003, the mother of the child John, Amanda Maksymetz made a statement to the Winnipeg City Police, regarding the events prior to the deceased's death in the early afternoon of the same date.

2. She related that she woke up at 6:30 a.m. She was in a separate room from the deceased. She heard John Erik Demery grinding his teeth from this room and heard some gurgling noises. She did not enter the room and then went back to bed, hoping that John would go to sleep.

3. At 8:30 a.m. she awoke again and heard John making gurgling noises and hitting the footboard of his crib with his feet. She told Mr. Allan Demery this and went to take a shower.

4. Allan Demery told police that he did not check on John right away as he was not concerned. Mr. Demery did not arise until 10:30 a.m. as was his routine. At 11:00 a.m. he went to check on John. John was sleeping.

5. No one apparently returned to check on John until 2:00 p.m. when Mr. Demery returned to John's room and found him dead.

6. John Erick Demery was born on April 18, 2001. He was the second child of the parents, the first being Allan Jr., born August 19, 1999. John was diagnosed with Down's syndrome and had as a major medical difficulty three holes in his heart. His medical treatment was known at birth to require extensive and ongoing medical treatment.

7. Social worker investigation revealed the mother, Amanda Maksymetz, to be mentally developmentally delayed to the point that it was felt that she would not be able to care for the child. Although the father Allan Demery Sr. was involved, the couple was living apart. The relationship was clearly unstable at the time of birth of John. The Social Work Department of the Health Sciences Centre made a referral to Children's Special Services.

8. On April 23, 2001 John went into cardiac failure. He was to undergo an emergency cardiology assessment. John suffered from variety of medical and mental disabilities related to Down's syndrome that became evident in the ensuing

months.

9. Throughout the period since birth to May 15, 2001, there was on ongoing process of assistance and evaluation undertaken by Winnipeg Child and Family Services (WCFS), with regard to John's and John's parents needs. It was determined that the combination of John being a medically high needs child, the cognitive and intellectual capacity of his mother and the lack of involvement, at the time of the father, required an apprehension.

10. John was placed under apprehension by WCFS on May 15, 2001. John remained under apprehension and placed in foster care until late 2002 and into early 2003 during which period an integration process with his parents was commenced. John was permanently placed with his natural parents in March 2003, shortly after which the formal legal relationship between John and WCFS ended. WCFS and its agencies remained involved with John to the time of his death on a voluntary basis.

11. As outlined in Exhibit 1, filed at this inquest, being a letter dated December 23rd, 2003, from the Chief Medical Examiner Dr. T. Balachandra, a Provincial Judge was directed to hold an inquest, under the discretionary provisions of s.19 (1) and (2) of *The Fatality Inquiries Act.*

12. The letter of the Chief Medical Examiner (CME) states that John Erik Demery was a two year old Winnipeg child who was found dead in his crib at home on August 15, 2003 by his father. During the course of the investigation by the CME, it was learned that John Erik Demery was born on April 18, 2001 at the Winnipeg Health Sciences Center. He had an extensive medical history prior to death that included Down Syndrome, deafness and a heart anomaly, for which he underwent specialized and extensive surgery in Edmonton, Alberta in the summer of 2001. John had remained a ward of the Province until November 2002, at which time his parents signed a series of temporary placement agreements, ending in February 2003. A reintegration/reunification process began in August/September, 2002 whereby WCFS was to return John to the physical care of the parents. John was returned to his parents gradually and in March 2003 the return was complete. WCFS ended its formal involvement with the family in May 2003, although there was ongoing support from WCFS and the Society for Manitobans with Disabilities up until the date of death of John.

13. In accordance with s.19 of the *Fatality Inquiries Act* a Provincial Court Judge was directed to hold a non-mandatory inquest into the death of John Erik

Demery with the following directions:

- to determine the circumstances that led up to this child's death;
- to determine what can be done to prevent similar deaths from occurring in the future.

14. Under s.33 (1) of the *Fatality Inquiries Act* a presiding judge on an inquest has a responsibility to:

- make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased person died, the cause of the death, the name of the deceased person, if known, and the material circumstances of the death;
- and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest.

15. In addressing those responsibilities, the presiding provincial judge must also be reminded of s.33 (2) (b) of that same Act which states that a provincial judge:

> shall not express an opinion on, or make a determination with respect to, culpability in such manner that a person is or could be reasonably identified as a culpable party in respect of the death that is the subject of the inquest.

16. The inquest as ordered was held on the dates as above noted, all at the City of Winnipeg, Province of Manitoba. The final date of the inquest was June 26, 2006 when final oral submissions, in support of previously submitted written submissions, where delivered by counsel.

II. INTRODUCTION AND INITIAL SCOPE OF THE INQUEST

17. It should be noted from the outset that this inquest did begin and proceeded in a functional manner. However, things changed.

18. The inquest, after several pretrial hearings and consultation with counsel, was to have proceeded to the taking of and the planned completion of evidence during the period of May 30 to June 17, 2005. It became apparent just before the opening of the inquest that the scope of the inquest, such as it was at that time, would require the calling of an additional 13 witnesses, so that a further two weeks were scheduled for April 2006. In the end, the inquest heard from a total of 29 viva voci witnesses. The inquest did not end until final submissions of counsel on June 26, 2006.

19. It is to be stressed that the scope of the inquest *potentially* changed upon the reception of medical evidence from Dr. C. Ferguson on June 8th, 2005, which was near the beginning of the inquest. The testimony of Dr. Ferguson at that time brought into consideration a real possibility, if not likelihood, that the cause of death of John Demery was one that was likely not preventable. More importantly to the scope of the inquest, based upon the conclusion on cause of death as suggested by Dr. Ferguson, this would potentially render irrelevant the majority of the testimonial evidence to that date, as well as testimony scheduled to be called but yet to be called.

20. It became apparent to the inquest that a major conclusion of the autopsy report of John Demery as to cause of death had been overlooked in the mandatory and optional investigations of various agencies and individuals prior to the inquest. Thus these investigations were potentially of limited assistance on the issues to be addressed by this inquest, although this was dependent upon what conclusions the inquest would arrive at regarding the cause of death and its preventability.

21. John was found to be harboring a very serious pathogen in his respiratory system at the time of death. The entirety of the relevant portion of Dr. Ferguson's testimony of June 8th, 2005 is set out as follows:

> EXAMINATION CONTINUED BY MS. TOLTON:
>
> Q His Honour had asked you earlier if there had been any referral of John Demery to the Child Protection Centre. Would you have expected any referral to the Child Protection Centre prior to July 26, 2003?
>
> A No.
>
> Q And would you have expected a referral after July 26, 2003, that visit to the E.R., to the CPC?

A No. No.
Q Thank you. Those are my questions.
THE COURT: Any other counsel? Because I have just a couple of questions.
EXAMINATION BY THE COURT:
Q My questions revolve around the cause of death, and the autopsy report, and I just want your answers to a couple of things. The immediate cause of death was bronchial pneumonia, due to, was eventually a lung culture taken, and there were two cultures taken that were found. If I could refer you to A6.1 in Exhibit 2, which is the autopsy report. And I'll let you have a look at that.
A Do they name the cultures also?
Q Yeah. But you know, I don't even attempt to pronounce --
A Give it a try. I'll tell you what they are.
Q My wife's a pharmacist and I can't pronounce a darn thing.
A Is it pneumococcus (phonetic) or haemophilus or --
Q No. It's staphylococcus.
A Staphylococcus.
Q Yeah. Aureus, which I guess is some form --
A Yeah. Well, that's a very serious pathogen. Staphylococcus is a, usually resistant to most antibiotics. It's usually a -- it's harboured on the skin, and so it's an unusual infectious agent, very, very lethal. It requires specific antibiotics to overcome. I don't know whether -- I guess --
Q It's a relatively rare type? Or --
A Yeah. I would say for pneumonia, yes, it is. And not common. The two I've mentioned to you are more common.
Q So a general spectrum --

A You said there were two cultures, though, didn't you?
Q Yes.
A What's the other one?
Q H-E -- H-A-E-M-O-P-H-I-L, influenza.
A Haemophilus. Yeah. Haemophilus is the one -- thank you. Haemophilus is the one that I mentioned, along with pneumococcus.
Q Yeah.
A Yeah. Okay. Yeah. That's in the autopsy findings No. 10. So he had a double infection with two agents. The second one is common. Haemophilus, H-A-E-M-O-P-H-I-L-U-S.
Q Is the staphylococcus, is a type of bacteria, that you say is --
A Staphylococcus is, yeah. They both are.
Q It's very lethal?
A Well, it's --
Q And you say relatively rare.
A It's an uncommon -- it's more uncommon than lethal to be in the lungs. But I mean, you have to pick your antibiotics to cover that.
Q That was my next question. Yeah.
A I think it would be -- I'm not sure today if they'd have picked an antibiotic to cover staphylococcus for pneumonia. I would imagine they would. It adds to the counsel's question as to whether they had a really great chance to save him or not. That would be a complication, staphylococcus, because I don't know if they'd be able to predict he'd have that. But he did.
Q When a child comes in for treatment, and there's an initial diagnosis of bronchial pneumonia, is it not the case that the initial treatment would be a massive

dose of antibiotics, but that it would be a general spectrum antibiotic, like Septra?
A Or more than one today.
Q Or more than one?
A Yeah. That's right.
Q But those general spectrum antibiotics would not necessarily have an effect upon this type of bacteria?
A They might not in this case. I think they cover staphylococcus, though, in the choice.
Q In the choice.
A It's virtually always two now. And one of them -- between the two, they cover just about everything. I suspect one of them would be staph., but I think everybody would be surprised to learn that this was what he had. But they wouldn't know that because they didn't continue -- he didn't get treated.
Q How long was -- how long was the child in the hospital before death?
A I think he was DOA, wasn't he? He was dead on arrival.
Q He was DOA. That's right. Okay. I'm sorry. Yeah.
A Um-hum.
Q That's correct. Okay. And then so all of this was post-mortem, culture and --
A Um-hum. Yeah. Exactly.
Q Would culturing be done prior to death with the child coming into a hospital to --
A Yeah. Attempts would be made.
Q Attempts to be made to identify the exact bacteria?
A Yeah. Yeah. Yes.
THE COURT: Okay. All right. Anything arising from that?

MR. ARENSON: Just one question, if I may.

EXAMINATION CONTINUED BY MR. ARENSON:

Q Your question about an attempt would be made should the child be brought into the hospital while he was still alive to culture the bacteria. How long would it take, normally, for that staphylococcus bacteria to be confirmed by the culture?

A Two or three days, probably.

Q Two or three days. And if there's a specific heavy duty so-called antibiotic, they wouldn't have known for two or three days, and by then, the child -- there might well have been lethal results before they would know the culture.

A That's possible. It's very -- it's always a concern that you have the proper coverage for the whole spectra of bacteria when you start out your treatment. And today, as most of you know, MRSA (phonetic), or staphylococcus aureus, is the big resistant organism now today in the hospitals. And so they have to be really careful of it. I don't know whether this one would have been tested for antibiotic resistance after a post-mortem or not. Nobody would even know that he had this, but this is, this is the germ that's in the hospitals that's running wild, and is antibiotic resistant.

Q So let me ask you, if they knew that he had the staphylococcus bacterium, they certainly wouldn't treat it with a broad spectrum antibiotic. They would have a more effective, more specific antibiotic.

A They would. Yes. They'd have to include that in the initial cocktail. And from my knowledge, they do, they have a multiple resistant staphylococcus, MRSA (phonetic), S.A. stands for staphylococcus aureus, so they have, they usually have a cover for that in any

child who would be as ill as this boy would be. It would be very precarious not to cover staphylococcus. But I don't know, I'm not -- I don't know what the drug is at the moment for that. But there is one.

Q Thank you.

EXAMINATION CONTINUED BY MR. GUTKIN:

Q I wonder, Dr. Ferguson, if you could just clarify a few matters arising from this issue of staphylococcus. You say it's your understanding that the initial antibiotic, or antibiotics, that would have been given to a child such as John Demery, would have included an antibiotic to cover staphylococcus?

A Yes.

Q That's your understanding of the hospital practice?

A Yes.

Q And my learned friend asked you about the cultures, Mr. Arenson asked you about the cultures, and it taking two to three days for the cultures to come back to confirm the type of bacteria.

A Um-hum.

Q Would it be fair to say that if a child came into the hospital, and cultures were taken, and it took a few days for the cultures to come back, would it be fair to say that over that two to three day period, if there was further deterioration in the child over that time period, then additional medications or antibiotics would have been tried prior to the cultures coming back?

A Oh, absolutely. Yes. Yeah.

Q Now, in terms of the staphylococcus bacteria, does that change the picture that one would see in this child in the days or week leading up to his death?

In other words, if I could be just a little

clearer on that, you've described a whole series of symptoms that one would see in a child who is suffering from bronchial pneumonia. Would there be anything additional that would alert a parent or a caregiver if the cause of the bronchial pneumonia was staphylococcus? Now, appreciating nobody, a parent or a caregiver, would probably not know that to be the cause, but would they see additional worrying signs?

A Well, yeah. The one thing that's pretty common to this organism is it's part and parcel of impetigo, or a skin infection. So there would have been open sores, or if there had been open sores, they almost certainly would have been cultured for this germ, which is a common condition in children which, as I understand it, he did not have.

Q Was there not an open sore, though, around his neck from the sling?

A Well, he had inflamed abrasions on the back of his head, but inflamed abrasions don't sound terribly, you know, terribly lethal to me. They might have been -- they might have been harbouring this germ.

Q But apart from what might be harbouring it, in terms of what a lay person would see, would there be additional signs or symptoms that any lay person would see and would raise concern?

A No. Other than --

THE COURT: Perhaps if you could add to that, perhaps, the rapidity of, the rapidness of the onset of signs.

MR. GUTKIN: Okay. I'll follow it up with that. Yeah.

THE COURT: In terms of this bacteria.

MR. GUTKIN: Yeah.

THE WITNESS: No. There would be nothing other than -- as I said, there have to be signs. They can't be symptoms, because the child can't tell you. So the

only sign would be a massive skin infection, or significant --

BY MR. GUTKIN:

Q And was there any evidence of a massive skin --

A No. No, I don't think there was. No.

Q But was there -- in terms of the rapidity of the onset of the signs, would the fact that there's a staphylococcus bacteria behind this pneumonia, would that have any impact on the rapidity of the onset of the signs?

A It might, it might, it might. It might have induced a rapid, a more rapid onset. Yeah. It's, it's a more lethal -- it's a more serious pathogen than the others.

Q And this rapid onset, if it occurred, would this be observable, would this be something that a layman would appreciate in a child as something indicating there was something wrong with the child?

A Yeah. Some laymen. But it is not uncommon for people to come in late who are reputable and observing. It's, it's something that comes up a lot, and I think a lot of us, as parents, luck out on this, you know. We just are there enough, and long enough and, well, I always claim that the real criteria are increments of change. Increments of change. In any illness. That's crucial. I feel this way now, or I see the child this way now, and in an hour, the increments of change are for the worse. Off you go.

Q Now, from your -- just so we're clear on this, from your observations of -- from your review of the records, including the post-mortem results with respect to this child, can you be any more specific in terms of increments of change of when these increments of change, if any, would have been observable prior to

John's death?
A Well, within the previous 24 hours, he would have been incrementally on his deathbed for sure. But I can't tell you exactly when they would have sort of begun.
Q And would that be apparent to a lay person?
A It would -- it should have been. But you know, it -- if you're there all the time, you have perhaps less chance to observe changes than you do if you're a visitor, or come in differently. That's why people always ask someone else in the family to have a look. But I don't know. I'm not sure about what the general level of observation was on this boy relevant to his signs. I have no idea.
THE COURT: Is this the bacteria that they generically call the flesh eating bacteria? Is this the same one?
THE WITNESS: It's related.
THE COURT: Or is it in the same family?
THE WITNESS: The flesh eating one is the streptococcus --
THE COURT: Oh, yeah. Okay.
THE WITNESS: Which -- they're the same family. Streptococcus. This is not that one. This tends to harbour -- it tends to be harboured in families on skin, and we see it as the major culture from impetigo, I-M-P-E-T-I-G-O, which is very common in children and -- but again, I don't think he had anything of that nature at all.
THE COURT: No. Okay. That's -- I was on the wrong track there. Okay. And in terms of what counsel is just questioning you -- now maybe I am anticipating what you're asking, counsel, but I tend to do that because sometimes my anticipations are wrong. This child had a compromised immune system.

THE WITNESS: Yes.
THE COURT: I mean, the immune system, one of the principal lines of defence of the body in terms of protection against invasiveness of bacteria --
THE WITNESS: Yeah.
THE COURT: -- is the immune system.
THE WITNESS: Yes.
THE COURT: How would that affect --
THE WITNESS: Well, I am sure --
THE COURT: A reduced immune system affect being able to --
THE WITNESS: I am sure it's a fact -- I am sure it's a factor here.
THE COURT: -- being able to defend against this type of bacteria?
THE WITNESS: Yeah. Yeah. But again, as I said a little earlier, we have no data, no laboratory data that proves that he had an immune defect.
THE COURT: Yeah.
THE WITNESS: Although I think if you read up the Down's syndrome articles, you'll find that that's listed in there as common.
THE COURT: There was nothing specifically with respect to this child, though, that was --
THE WITNESS: I don't see there was any data on that, nor was it investigated, to my -- anything I saw. But I have -- I think it would be fair for the court to assume that that was a factor in this. Staphylococcus is what we call opportunistic, and you know, he was, he'd be a sitting duck for this type of thing.
BY MR. GUTKIN:
Q Can I just -- in terms of the child being a sitting duck for this type of infection --
A Um-hum. Yeah.

Q -- as a doctor, would there be some special instructions that would be given to parents with children like this, with children who have immune system deficiencies such as Down's syndrome, children who are more susceptible to these type of diseases? Would that be something that the medical people working with a family would help the family appreciate, and give them instructions on?

A Yeah. I would think so.

Q And could you tell whether that occurred in this case?

A No. I don't -- I don't know. Many families who have Down's syndrome children are in communication with other families. And of course, they learn massively from each other, 'cause some children who have Down's syndrome function almost normally in every way, almost, and intellectually as well as physically. There are many variations on the theme. And -- but in this matter, I am not sure any advice was given along those lines.

Q So you say that with families of Down's syndrome children, it's often the families themselves basically support each other?

A Absolutely.

Q There's a support network of, at least of families involved, to help each other to cope with what would otherwise be a very difficult child to bring up?

A Yeah. Yeah. Exactly. That's right.

Q And could you, from your review of the material in this case, determine whether there was any such support network in place for this family?

A Not that -- I think that they were very independent of the systems, if they could manage it. And that's not, that's not a criticism. I think that

> they were trying to be as independent as they could with a very considerable burden, and I wouldn't think that would be in their sphere, association of Down, nor would they even be aware of it.
> Q Just to follow up on that, would it be your professional opinion --
> MR. FROST: Excuse me, Your Honour. We're way past the questions around the infections that you've talked about. We're back into support. We're really pushing this. The first question was okay. Now we're -- Terry's -- Mr. Gutkin is --
> THE COURT: Yeah. It's questions that are --
> MR. GUTKIN: I almost think that I am sitting here as an adversary to Mr. Frost, 'cause he pops up every time I ask one question too far.

22. This testimony caused some surprise and consternation to all parties concerned. If the cause of death was by this lethal pathogen and even the most attentive parents would potentially not have been able to have the child brought to saving medical care in time to prevent death, then what should be the scope of the inquest? Should the inquest continue on to examine and make recommendations pertaining to the entire history and involvement of governmental agencies with John? Or should there be a more restrictive scope to the inquest given that the medical evidence regarding this death may be an instance of essentially non-preventable death? Although Dr. Ferguson was qualified as an expert in his field of child abuse and medical findings related to child abuse, he was not an expert in the field of bacteriology or pathology so that his opinions alone could not be used by the inquest to reach any conclusions.

23. After consultation with inquest counsel, and given that further medical expertise was not available until April when the inquest was scheduled to resume, it was decided to continue with the inquest assuming the broader scope, until such time as the expert medical evidence was called. Upon calling of the expert medical evidence at the inquest, all parties would then be in a better position to make assessments regarding the medical evidence and cause of death. If such expert medical evidence to be called did not support the tentative non-expert conclusions of Dr. Ferguson, then the non-medical evidence up to that time would be on the

record. There would be no further delays in the inquest and both the wider and the potentially more limited scope of the inquest would be preserved. The inquest thus adjourned on June 17th, 2005 until the calling of Judith Hoeppner, John's foster parent on December 14th, 2005. The inquest again adjourned after that one day to February 27th to March 2, 2005 to hear from non-medical witnesses.

24. Expert medical evidence on the issue raised by Dr. Ferguson was not available until the testimony of Dr. Pierre Plourde on May 31st, 2006. Dr. Plourde was qualified to give expert testimony with respect to infection control and infectious diseases. He is a co-medical director of the Regional Infectious Control Program.

25. Portions of the testimony of Dr. Plourde are set out as follows:

> EXAMINATION ON QUALIFICATION AS EXPERT BY MS. DZIK:
>
> Q Good morning, Dr. Plourde.
>
> A Good morning.
>
> Q You understand you've been called here today as a witness to assist the court in understanding some of the symptoms and effects for bronchopneumonia; is that right?
>
> A Yes.
>
> Q And you work for the WRHA; is that right?
>
> A Yes.
>
> Q And can you tell us what your role is there?
>
> A I'm one of the medical officers of health. I also wear several other hats, including one that relates to infection control and infectious diseases. I am one of the co-medical directors of the Regional Infectious Control Program and I also continue to practice infectious diseases on a part-time basis.
>
> Q Can you give us a little bit of background in terms of your experience in infection control?
>
> A My experience in infection control includes five years as the Director of Infection Control at St. Boniface Hospital from 1995 to 2000. At the time I

was also a full time infectious diseases consultant again working in a tertiary hospital care setting.
Q And I think your C.V. has been handed out to everyone and there's copies for the court and I believe there's a copy in front of yourself. Is that your C.V.?
A Yes, it is.
MS. DZIK: And maybe we could have that tendered as the next exhibit. I think it's Exhibit 54.
THE CLERK: Exhibit 54.
THE COURT: Exhibit 54.

EXHIBIT 54: CURRICULUM VITAE OF DR. PIERRE PLOURDE

BY MS. DZIK:
Q Now, are you familiar with a child by the name of John Demery?
A Yes.
Q And did you have any direct involvement with his care or his case?
A No.
Q Okay. So how are you aware of the case?
A WRHA counsel handed me the, the file to review it and comment on the bronchopneumonia aspects.
Q And are you aware that he died on August 15th, 2003?
A Yes.
Q So it's my understanding that you've reviewed the medical reports, the lab report and the autopsy report?
A Yes, I have.
Q And the autopsy report shows --
THE COURT: I'm sorry, you reviewed the lab report, the autopsy report, and sorry, what else?

MS. DZIK: Medical records.
THE COURT: All right. And all of these things that the witness has reviewed is in the material before me?
MS. DZIK: Yes. Yes, Your Honour. It's Exhibit 38 and the autopsy report is found, I believe at Exhibit 2. The medical records are found in Exhibits 3 and 4.
THE COURT: The lab report, yeah, I've seen that, Exhibit 38?
MS. DZIK: Yes.
THE COURT: And the medical records, Exhibit 3 and 4? So these are, these are the same --
MS. DZIK: Yes.
THE COURT: -- documents? Okay.

BY MS. DZIK:
Q Now, the autopsy report shows that the cause of death is bronchopneumonia; is that right?
A Correct.
Q Generally, can you describe to the court what the symptoms of bronchopneumonia might be in a two-year-old? We understand that John Demery was two years old?
A Right. The, the classical -- it being a lung infection, the classical symptoms you might expect would be fever, cough and difficulty breathing or grunting respirations or rapid respiratory rate. Having said that, not infrequently in a two-year-old the symptoms may be very non-specific. You may simply have an irritable child, not feeding well, just not happy, not their normal personality. They may or may not have appreciable fever as well at, at the initial stages of the infection. And they may even have symptoms that are very confusing steering away from this side of the infection in the lungs, but symptoms

that are gastrointestinal, like vomiting, nausea, vomiting and even on occasion diarrhea.

Q Now, are you able to indicate how long it would take for any of those symptoms to show in a two-year-old with bronchopneumonia?

A It depends on the cause. An acute viral bacterial infection you're talking hours to days for the development of, of symptoms and, and more rapid progression of a chronic pneumonia, fungal or tuberculosis, can take weeks or months to evolve and develop, but (inaudible) so I'll leave it at that for now.

Q Okay. And, and staphylococcus aureus, would that be an acute form?

A Right. So that bacteria would typically present as an acute pneumonia and you're talking developing symptoms over hours to days.

Q So are you able to indicate again whether there's any ability to predict how long it would take for bronchopneumonia to cause deterioration in a two-year-old child?

A Again it, it, it will vary, but if this particular organism, staphylococcus aureus, it can be very rapid.

26. Page 6, line 8 to page 9, line 2:

Q Now, we're speaking generally about symptoms and deterioration from bronchopneumonia and specifically staph aureus. Can you indicate whether having Down Syndrome would have any effect on bronchopneumonia and its symptoms and deterioration?

A Having Down Syndrome will, will have a major effect. Children with Down Syndrome have various

abnormalities that render them much more susceptible to these infectious diseases and when they become infected have much higher mortality rates. We're talking in the area of -- for pneumonia 60, 60 times, 60 fold higher risk of pneumonia in a Down Syndrome child over an otherwise normal child and a Down Syndrome child with pneumonia or with any infectious diseases has up to ten times higher mortality rates than a child who felt otherwise normal.

THE COURT: I'm sorry, I missed the differentiation between the 60 and the ten.

THE WITNESS: Sixty times more likely to get pneumonia.

THE COURT: Oh, I see.

THE WITNESS: And the reasons -- there are reasons for that. Partly the low muscle tone, the inability to clear the respiratory secretions very well, the problems with feeding that lead to aspiration, as I believe this child has feeding problems.

THE COURT: Are you talking specifically about pneumonia or are you talking generally about --

THE WITNESS: Just --

THE COURT: -- infectious disease?

THE WITNESS: -- pneumonia. The, the lung being at risk. So that low muscle tone, the fact that they may aspirate contents that shouldn't be in the lung into the lung.

THE COURT: Oh, I'm sorry, maybe my question should be more specific. In terms of susceptibility and in terms of higher mortality rate you're --

THE WITNESS: The 60 fold is pneumonia --

THE COURT: -- talking about -- specifically about pneumonia?
THE WITNESS: The lung, yes. And, and the mortality rate would apply to that as well.
The, the other reason for susceptibility and a poor outcome is their immune system -- this is not well defined in the literature, but they do not have what is known as -- their, their immune function is not normal. It may be a combination of their so-called T cell immune function and the cells that produce antibodies, the B cells. They may have different defects in their immune system that again make them both more susceptible and high mortality should they become infected.
THE COURT: This is --
THE WITNESS: Down Syndrome.
THE COURT: This is on a DNA basis, DNA --
THE WITNESS: I don't think they, they clarified that, so it's not a well understood defect, but it is know that that just their immunes just do not function as well as, as they should.
BY MS. DZIK:
Q Now, are you aware of any information that a Down Syndrome child would be asymptomatic for pneumonia or would have any different symptoms than a child that does not have Down Syndrome?
A Not aware of, of that at all. In my own limited pediatric experience, but I also have consulted pediatric infectious disease colleagues to find out from them as well, and no, there, there's no such entity that we know of.

Q Now, in this particular, in this particular circumstance, upon your review of the documents, the medical records, the autopsy report and the lab report, was there anything that indicated to you the symptoms that this particular child had for bronchopneumonia?
A The, the symptoms the child had, if any, appeared to be very non-specific and do not point to the lung as, as a source of disease, from what I can see.
THE COURT: Okay. And what were those factors that you were aware of?
THE WITNESS: There is mention of, of dehydration in the record. There is mention of diarrhea. It all points towards a gastrointestinal problem. Now, as I mentioned before, those symptoms can occur in a case of pneumonia, but they certainly don't point to it.
BY MS. DZIK:
Q Now, so, so in this particular case were you able to identify from the records how many days before death, which was August 15th, that John Demery would have developed symptoms?
A Again, it's not evident in the record. The last medical record is somewhere around July, I think, 26th, if my memory recollection is correct and there were no symptoms then identified of any infectious disease. So anywhere in that two and a half week timeframe from then to death he could have developed symptoms. Again with that organism if we're going to, to blame the as the cause of the bronchopneumonia, we're talking literally hours to days of symptom development.

27. Page 13, line 1 to line 14:

> . . . It appeared to have a well contained right lower lobe bronchopneumonia and one might presume that it might -- it could potentially have been amenable to aggressive therapy. I can't predict what the outcome would have been. The mortality, by the way, from staph aureus pneumonia is around 30 percent.
> THE COURT: I'm sorry, the what?
> THE WITNESS: Mortality. The, the chance of dying from this infection, even with the best of treatments, is about 30 percent. So you've already got the odds stacked against this, this patient, but the fact that the pneumonia appears to have been quite contained suggests that it may have been amenable to aggressive antibiotic and supportive therapy.

28. Page 18, line 33 to page 21, line 25:

> Q And from -- if I understood again your evidence correctly, what you believe to have occurred, may have occurred, was that he aspirated or dragged down into his lung some fluids and organisms that would (phonetic) ordinarily be in his mouth?
> A Right. And the two pieces of evidence that are within the autopsy report, the description of foreign body giant cells within the lung are evidence of previous aspiration, and we know from his feeding history that that may have been an issue. The other compelling piece of evidence is the anatomy. There's a much more direct tube from the throat to the right lung. The left lung takes a 90 degree turn. It's much more indirect. So aspiration pneumonia is most commonly found in the right lower lobe. That's a very typical location for aspiration pneumonia.

Q Okay. And, and when we're talking about sort of choking it down into your lungs, I mean, I guess we all do that at some point when we drink something inappropriately --
A Yes.
Q -- or we're swimming in a pool --
A Yes.
Q -- and we choke?
A Yes.
Q That's the type of what we're talking about --
A Yes.
Q -- getting fluid into your lungs?
A And it will most likely end up in your right lower lobe --
Q And so --
A -- on just by odds.
Q And so sometimes it will cause a pneumonia and sometimes not?
A It'll cause an inflammation and that may just resolve or progress on to something more serious.
Q In a child who -- or as I understood your evidence, the staphylococcus aureus infection that causes the pneumonia has, has just by virtue of the fact of having it, a 30 percent mortality rate?
A It's, it's a bacteria that one can both carry, as you've mentioned, and have absolutely no harm from it. It's also a bacteria that can kill very rapidly.
Q So once you've got an infection caused by a staphylococcus aureus in your -- the lung, the chance of you surviving that is somewhere in the range of 70 percent?
A Right.
Q Or 30 percent will die?
A On average.

Q Yeah.
THE COURT: For, for children?
THE WITNESS: On average for a population as a whole, children and adults combined.
BY MS. VAN IDERSTINE:
Q And if I understood your evidence earlier, just by the fact that John Demery had Down Syndrome and thus has maybe perhaps a compromised immune system, he would have a ten percent greater chance than the average of dying from that; is --
A Tenfold.
Q Tenfold.
A Ten times.
Q Sorry, that's what --
A So you can't really multiply 30 percent --
Q No.
A -- times ten. That you're basically a very high risk of death from the disease.
Q So in a child who has Down Syndrome the fact of getting pneumonia is going to be a serious illness --
A Yes.
Q -- and a serious concern?
THE COURT: And 60 times more likely to get the infection.
THE WITNESS: Yes, in the first place, correct.
BY MS. VAN IDERSTINE:
Q Yes. Meaning he's more susceptible than the average to even getting this disease?
A Yes.
Q John had a history of having -- in past having -- he had congestive heart failure which had been repaired about six months earlier.
A Yes.
Q Would that have had any effect on his pneumonia?

A That would increase his chance of dying from it, so that certainly would not help him, but be another strike against him.
Q And again, as I understood your evidence with respect to the speed with which these pneumonias might develop, that your best guess on this is that it may have developed as quickly as a couple of hours before his death to maybe a few days before his death?
A Yes.
Q But not weeks before his death?
A No.

29. Page 28, line 2 to page 29, line 30:

Q -- because it was Down Syndrome you'd use the, the figure of ten times the, the normal mortality rate for an infection like this?
A Or infectious diseases in general in Down Syndrome.
Q So it brings it sort of off the scale --
A Yes.
Q -- in terms of mortality?
A A very high mortality rate.
Q Now, that is with -- that mortality rate is in a situation, in a hospital situation where there is treatment that's provided?
A Yes.
Q So this child would have had a very high mortality rate even had treatment been provided?
A This child's prognosis would have been poor from the outset.
THE COURT: Prognosis poor in terms of an outcome of --
THE WITNESS: Meaning --
THE COURT: -- death?

THE WITNESS: -- an outcome of death as a real possibility, yes.

BY MR. ARENSON:

Q Now, in your experience with parents with sick children, and, and I'm not -- just recognizing the illness, it's not easy, is it?

A Very difficult in a non-verbal child. It's, it's a bit of guesswork. Unless they're -- you happen to see them shaking with a chill and their temperature is sky high and you measure it and, and you realize you've got a problem, it's, it's very non-specific. The child may simply be crying all the time, just very irritable and refusing to feed.

Q And, and as you said, sometimes the child can display symptoms that one normally wouldn't associate with pneumonia, such as diarrhea?

A Right. That confuses -- you know, the diarrhea might still be indicative of a serious problem, but in this instance it may be pointing to the wrong anatomy; that the, the, the focus of disease is actually in the lung, as it turned out in this case.

Q And again, the issue of fever, it may present with fever and it may not present with fever; is that accurate?

A It, it may not. It may actually present with the opposite of a lower body temperature or what we call hypothermia, so it can be difficult even to rely on fever alone.

Q And is it a, a problem or do you recognize that it's a problem, and I'm not sure how it's treated in terms of medical training, but about parents (a) recognizing the, the serious of, of the, of the infection and (b) knowing when it's time to bring the child to hospital? Is that, is that a common problem

for parents bringing to children hospital late?
A From my own personal experience, a father of two children, that is a very difficult decision to make even for the expert. It is one reason we have a service like Health Links I (inaudible) to assist parents in making that decision and, and phoning a health care professional who can help make that decision over the phone because it certainly with a non-verbal child is not an easy decision to make.

30. Page 31, line 7 to line 34:

Q And, and when you talk about aspiration into the lung, that was, that was sort of a --
A Probably a common occurrence of this child --
Q Yeah.
A -- from the feeding history.
Q And an ongoing occurrence?
A Yes. So it's, it's -- in answer to your question, could -- might this have not been preventable, I'm trying to provide you with the evidence of its support, that contention this child may have been a carrier of those organisms. This child had a problem already that may have put those organisms into the right lower lobe of the lung. This child's immune system was already weak and it may have been an inevitable possibility.
Q So then to put it in a reverse way, those who would have describe this death as being preventable, you would disagree with that if they're saying this death was preventable without the qualifications you've enunciated?
A Yeah. Any -- we look upon any staphylococcus aureus death as potentially preventable, but you're playing, you know, what are the odds here in this kind

of scenario, and again I would use the same terminology you did, it -- you know, if you were to ask me, may have this death been preventable, I would have said, well, there's a -- it may have been, but the odds are certainly hugely against this child having a, a good outcome from that kind of infection.

Q By a good outcome, you mean survival?
A Survival.

31. Page 36, line 2 to line 34:

Q In this particular case we have heard evidence that John Demery had been suffering from diarrhea for a number of days. The, the notes that I have with respect to some of the witnesses who testified, that prior to the child's death this child had been suffering from diarrhea from three to four days. Were you aware of that?
A Yes.
Q And that suffering from diarrhea over that lengthy period of time, that's the type of thing that can cause severe dehydration in a child?
A It certainly can.
Q And a child who has to fight off a very serious infection such as staff, the ability of that child as the days go on with the child becoming more and more dehydrated with diarrhea, the ability of that child to fight off that infection becomes worse and worse?
A Right. Primarily because the dehydration has produced severe chemical imbalances.
Q On a child who is suffering from dehydration, from -- I'm sorry, from diarrhea for more than -- severe diarrhea for more than a couple of days, have been attended to, in your view, at a hospital?
A I'm sorry, repeat the question.

Q If a child in -- especially a child with John Demery's susceptibilities, his, his Down Syndrome problem, his, his history of having a previous congestive heart failure that albeit was treated, a child like that who is starting to show severe diarrhea over a day or two, is that the type of thing that would necessitate or should have necessitated that child being taken to the hospital for treatment?
A That's why I would counsel parents of that child not to sit on any unresolving illness for very long.

32. Page 46 (re-exam by Arenson):

Q Doctor, just a point of clarification. When you cited in your direct evidence the mortality rate of 30 percent and then you've described that in, in, in questioning by me earlier that, in fact, it's probably higher for children, and then you throw in the factors that we've talked about, such as Down Syndrome where you said there's a ten times greater likelihood of mortality, and the factor that this child was non-communicative, non-verbally communicative, I want to ask this. And we've heard questions, well, if the environment had been different, if, if the diarrhea had been handled differently or if the temperature wasn't so high, and you've said, well, all of these things -- in, in fairness I believe your answer is that it, it certainly wouldn't have, wouldn't have hurt, it may have helped.

But I'm going to suggest to you that -- and see if you agree with me, that the essential mortality risk here, under the best of circumstances, the best of treatment and early medical intervention would not have appreciably changed the mortality rate that, that apply in this case, that there was still a very high

probability of a, of a, of a fatal outcome; is that --
A Yes.
Q -- is that fair?
A Right. It's, it's an order of magnitude. So we're -- would you have been able to reduce the mortality from over 90 percent to 80 percent, it's still -- the reduction it's still a very high mortality.
Q Under the best of circumstances?
A Right.
MR. ARENSON: Thank you.
THE COURT: All right. I just have some questions for you, Doctor.

III. FINAL SCOPE OF THE INQUEST

33. As a result of the combined evidence of Dr. Ferguson and Dr. Plourde the inquest finds as follows:

1) John died of bronchopneumonia via bacterial infection, resulting in suffocation due to fluid build-up in the infected lung tissue.

2) Cause of death was natural.

3) Cause of death was likely not preventable by the parents or by any other known and reasonable interventions.

34. It is because of finding 3) that the scope of this inquest report must be limited.

35. Although the Report of the Medical Examiner (Exhibit 11, Tab 1) and the Child and Family Services section 4 report (Exhibit 22) are comprehensive and valuable for their purposes and scope and they make a number of recommendations pertaining to systemic, personal and organizations structures and communication, they did not have available to them the medical evidence available to this inquest.

36. It is unfortunate that the testimony of Dr. Plourde was heard so late in the inquest. For instance, evidence was heard that John was hospitalized on July 26th, 2003, some three weeks prior to his death for a spiral fracture of the arm. This fact

was potentially central to any finding or recommendation of the inquest, as this naturally raised concern about the parenting abilities of John's parents. Also, although just recently having been under care of WCFS, the injury was not reported by hospital staff to WCFS. All of this potentially impacted on inquest findings and recommendations. In the end, it does not.

37. The scope of this inquest must be limited to an analysis of facts relevant to the above-noted findings, particularly that the bacterial infection resultant in John's death was likely to take his life, no matter what pre-infection or post-infection interventions or changes might have been made. Recommendations emanating from any inquest must be ones realistically capable of being able to reduce the possibility of death in the future in similar circumstances.

IV. SUMMARIZATION OF FACTS: RATIONALE AS TO THE FINAL SCOPE OF THE INQUEST

38. John was born on April 18, 2001. He began his life with major medical complications. Complications known shortly after birth included the following:

- Down' syndrome, with associated physical and mental disabilities, including:
- auditory functioning and compromised immune system
- Major heart defects
- Mentally challenged, with low I.Q.

39. In addition, John's mother had limited cognitive functioning. The father was actively involved with John, but the parents were not living with each other. Even if medical exigencies permitted, it was not advisable to have John under the sole care and control of the mother. Both would need to be educated with respect to John's special needs, medically, physically and emotionally, a task that was in part delegated by WCFS to Society for Manitobans with Disabilities. Given all of these factors Winnipeg Child and Family Services apprehension of John was inevitable and occurred under the auspices of WCFS on May 15, 2001. The need for the apprehension was not, and has never been, an issue.

40. After apprehension John was placed with a specialized foster parent, a registered nurse, Judy Hoeppner. John remained under her care throughout 2001, 2002 and in very early 2003. This was necessary given the medical high needs of John, both before and after the surgery, the incapacities of the mother and the

fluctuating nature of the relationship of the parents. The advisability of this placement was not an issue at the inquest.

41. In the summer of 2001, John underwent successful major heart surgery in Edmonton. The parents had visitation rights with John throughout that was generally well exercised. This included accompanying the child for an extended period while John was in hospital for surgery in Edmonton. CFS social workers remained involved with the natural parents, with John, Ms. Hoeppner and outside contracted and non-contracted agencies assisting with the care of John and assisting the parents throughout the life of John. A contracted agency, the Society for Manitobans with Disabilities began having, and continued to have, relatively intensive and ongoing involvement with John and his parents beginning early in his life and continuing past the end of Temporary Guardianship and later even after the termination of Voluntary Placement in May 2001.

42. John remained with Ms. Hoeppner throughout his life until early 2003 as the reintegration process, to his natural parents, begun in August 2002, had progressed. John thrived with Ms. Hoeppner, as best he could under his medical circumstances. The natural parents were gradually allowed increased visitation, overnight access, and weekend access and eventually the return of John to them in March 2003

43. Ms. Hoeppner expressed considerable and well communicated concern, both to WCFS and SMD regarding the reintegration process of John with his natural parents. Generally speaking her concern revolved around her opinion that the natural parents were not yet capable of caring for the needs of John. Although John, by the end of 2004, had all of his life-threatening medical conditions repaired, he was still a high needs child in terms of time and attention required by any caregiver. Ms. Hoeppner's concerns were well expressed and had a true factual basis. WCFS and SMD held discussions and a joint meeting in early 2003, before the return of John to his parents, to discuss these concerns. The concerns were considered to be met. It was a failing of the organizational structure, since corrected the inquest was told, of both SMD and WCFS that more or any consultation was had with Ms. Hoeppner. However, such consultation taking place would have been irrelevant to the cause of death.

44. The reintegration process and all parties involved in that process was the subject of much testimony and evidence. The reunification worker, Erwin Thiessen and the more involved WCFS social worker, Chris Campbell, were extensively questioned and cross-examined with respect to their roles. The organizational structure surrounding these two witnesses thus also became the subject of considerable testimonial evidence.

45. It would be accurate to suggest that the vast bulk of the inquest was engaged in an in-depth factual review of the entire child welfare process to determine if there might be some recommendations that, if followed, would have altered the course of events such that the death of John might have been prevented. Testimony included a detailed analysis of the structure of child welfare in Manitoba, major changes already made to this structure, the impact of such changes, worker caseloads, individual and daily organizational and individual decisions made by WCFS, SMD and their staff impacting upon John. A day-by-day, memo-by-memo and note-by-note detailing was provided to the inquest.

46. Such detailing was at the time essential and required given the uncertain scope of the inquest after the testimony of Dr. Ferguson on June 9th, 2005. Ultimately the detail provided was not necessary.

47. By law, and by operation of the originating request by the Chief Medical Examiner, recommendations of this inquest are to be restricted to those things that may be done, as required by the *Fatalities Inquiries Act*, and as directed by the Chief Medical Examiner, to prevent similar deaths from occurring in the future.

V. RECOMMENDATIONS

<u>Recommendation No. 1</u>: Manitoba Child and Family Services is to deliver mandatory training to social workers pertaining to the special medical risks and needs of children with Down's syndrome.

48. The inquest became well versed, mainly through the testimony of Dr. Plourde that those in charge of the care of children with Down's syndrome need to be especially vigilant regarding infectious diseases. The undisputed testimony of Dr. Plourde indicates that such children have 60 times more likelihood of bacteriological infection. When such infections occur, their mortality rates are much higher than other children due to their compromised immune systems.

49. To repeat and empathize the testimony of Dr. Plourde:

> A. Having Down Syndrome will, will have a major effect. Children with Down Syndrome have various abnormalities that render them much more susceptible to these infectious diseases and when they become infected have much higher mortality rates. We're

> talking in the area of -- for pneumonia 60, 60 times, 60 fold higher risk of pneumonia in a Down Syndrome child over an otherwise normal child and a Down Syndrome child with pneumonia or with any infectious diseases has up to ten times higher mortality rates than a child who felt otherwise normal.

50. As well, Dr. Ferguson described John as being a "sitting duck" for this type of infection. Children *without* John's circumstance of decreased immune system functioning, upon a respiratory infection of this nature, by this pathological agent, staphylococcus auerus, have an overall mortality rate of 30%, variable in individual circumstance. Children *with* John's circumstance of decreased immune system functioning have a mortality rate 10 times higher.

51. Although John's pediatrician was aware of John's compromised immune system as a known complication of Down's syndrome, she was not questioned with respect to this issue in depth as it was not a major issue when she testified on May 31st, 2005.

52. Thus it was likely that John would have died, given even the most ideal parental response and the earliest treatment. Once his lungs became infected with the bacterial agent, staphylococcus aureus, his odds of survival were extremely diminished.

53. Increased training of social workers would make them aware of these special risks.

54. This recommendation assumes such training, once delivered would include the necessity to train and advise all those persons physically in charge of, or to be prospectively in charge of, a child in care, to have similar knowledge.

Recommendation No. 2: Society for Manitobans with Disabilities is to deliver appropriate training to its relevantly engaged workers pertaining to the special medical needs of children with Down's syndrome.

Recommendation No. 3: Any mandated or non-mandated agency is to deliver appropriate training to its relevantly engaged workers pertaining to the special medical needs of children with Down's syndrome.

VI. SUMMARY AND CONCLUSION

55. Regrettably, the death of John was likely not preventable. A number of recommendations were made to the inquest pertaining to training and reporting issues involving the parties to this inquest. In particular I have considered the well thought out and submitted recommendations emanating from the Society for Manitobans with Disabilities, Winnipeg Child and Family Services and the Department of Family Services and Housing Directorate.

56. However, the scope of an inquest is to be limited to those recommendations that are relevant to the cause of death and its preventability in similar circumstance. For reasons already indicated these procedural and consultative recommendations are not relevant to that scope.

57. John's predisposition to bacteriological infection was not well known to the parties that took care of him. This is a failing and has been addressed in inquest recommendations. However, in this instance, the bacteriological infection was likely not preventable by any means. Once having been infected, the detection of the infection was problematic, even by the best of caregivers.

58. Once such an infection becomes symptomatic, if it does become symptomatic, and even if it was then detected at a very early stage and immediate and appropriate medical intervention was given, John's odds of survival were nevertheless considerably diminished.

59. The inquest, in complying with its mandate, thus declines to make further recommendations on procedural, consultative or organizational matters.

I respectfully submit my recommendations and conclude this report this 19th day of December 2006, at the City of Winnipeg, in Manitoba.

"original signed by:"
Judge Fred Sandhu

EXHIBIT LIST

	Description
1.	2 page letter dated May 26/05 from Alex Arenson to Prov Court
2.	Package of documents received from the Office of the Medical Examiner
3.	Package of documents from the Winnipeg Health Authority - Section 11
4.	Package of documents from the Health Sciences Centre - Section 11B
5.	Package of documents from Dr. Charles Ferguson, Section 11C
6.	Package of documents from The Society of Manitobans with Disability
7.	Package of documents from Winnipeg Child and Family, Section IV, A
8.	Package of documents provided by Child and Family Services, Section IV, B
9.	Package of documents provided by WCFS, Section IV, C
10.	Package of documents provided by Janet Grabowski
11.	Package of documents from Child and Family Services, General Authority
12.	Package of documents from Director of Child & Family Services
13.	Videotape of Amanda
14.	Videotape of Allan Demery
15A.	Corporate Policy & Procedure Manual dated 87/01/09
15B	Corporate Policy & Procedure Manual dated R1 95/06/22 & R2 04/01/20

Description

16. 2 page report written by Marion Bremner

17. 2 page list of appointments of staff of SMD

18. 5 pages Policies/Procedures for the facility - Based Communication Centre for Children

19. 1 page letter labelled curriculum vitae of Heather Martin-Brown

20. 1 page curriculum vitae of Leslie Assor

21. 3 page curriculum vitae of Lelie Highmoor

22. Section IV Review by George MacDonald

23. 10 page curriculum vitae of George MacDonald

24. Package of The Child & Family Services Act

25. 1 page flow chart of Winnipeg CFS

26. 1 page email from Chris Campbell to E. Thiessen

27. Notes of Maxine Maksymetz

27A. Original notes of Allan Jacob - various dates

27B. Original notes of Maeva Bradley - Feb 27/04

28. Notes of Judy Hoeppner

29. Promise of Hope document

30. Transcribed notes of Chris Campbell

31. Affidavit of Maxine Doreen Maksymetz sworn Jan 15/04.

32. Guardianship assessment dated March 23/05, 6 pages

33. Intake Transfer Summary, dated April 19/01, 5 pages

Description

34. Winnipeg CFS Family Support Services Request/Renewal form, 2 pages.

35. Winnipeg CFS Family Services Request/Renewal form dated April 23/01, 2 pages

36. Elsie Edwards résumé, 2 pages

37. Winnipeg CFS Family Support Services contact notes dated May 10/01, 6 pages

38. Lab results from autopsy

39. Hoeppner's notes re-written

40. Case Management Process & Standards

41. Case Transfer Summary

42. E-mail from Heather Martin-Brown dated May 6/03

43. Curriculum vitae of Linda Marie Burnside

44. Chart - Child Death Review Process

45. Curriculum vitae of Angela Balan

46. Family Preservation & Reunification Program - referral status

47. Curriculum vitae of Robbi Kaminsky

48. Curriculum vitae of Dennis H. Schellenberg

49. Agreement for Advisory Services under $10,000

50. Curriculum vitae of Dr. Michael Stambrook

51. Letter dated August 31/04, synopsis report

52. Curriculum vitae of Darlene Frances MacDonald

Description

53. Winnipeg CFS Child Death/Serious Injury Protocol

54. Curriculum vitae Dr. Pierre J. Plourde, 11 double sided pages

55. Online textbook of bacteriology “staphylococcus”, total 11 pages

56. MMWR Weekly August 20, 1999, Case Reports “Staphylococcus aureus”, total 4 pages

57. Irwin notes after presentation (Erwin Thiessen), total 8 pages

58. Chris Campbell, work experience, 3 pages

59. Chris Campbell, email copy, 1 page, March 4/03

60. Intake Application, Children with Disabilities Program, 3 double sided pages

61. 3 page CFS Standards Manual, Introduction 1.1.0

62. 7 page CFS Standards Manual, assessment 1.1.2

63. 5 page CFS Standards Manual, planning 1.1.3

DISTRIBUTION LIST

1.	Dr. A. Thambirajah Balanchandra, Chief Medical Officer
2.	Chief Judge Raymond E. Wyant, Provincial Court of Manitoba
3.	The Honourable David Chomiak, Minister Responsible for *The Fatality Inquiries Act.*
4.	Mr. Ron Perozzo, Deputy Minister of Justice & Attorney General
5.	Mr. Brian Kaplan, Director Regional Prosecutions and Education
6.	Ms. R. Malaviya, Provincial Counsel to the Inquest
7.	Mr. I. Frost and Ms. J. Mann, for the Department of Family Services and Housing Directorate
8.	Mr. T. Gutkin, for Child and Family Services General Authority and Mr. George MacDonald
9.	Mr. J. Myers, for the Society for Manitobans with Disabilities
10.	Mr. M. Thomson, for Winnipeg Child and Family Services
11.	Ms. H. Van Iderstine, for Dr. Marilyn Raizen
12.	Ms. M. Dzik and Ms. C. Tolton, for Winnipeg Regional Health Authority
13.	Mr. A. Arenson, for the Parents