Presiding Coroner's Comments

Background

Seven-month-old Kaiya Stone-Kirk came to her death on August 1, 2021 in Upper Liard, Yukon Territory. Kaiya and her 17-month-old brother were the subject of an Extended Family Care Agreement ("EFCA") between the Department of Family and Children's Services ("FCS"), their parents, and their maternal grandmother. Under the EFCA, their parents retained custody, but their grandmother was their primary caregiver because their parents were unable to care for them. Kaiya, her brother, her mother and her grandmother were members of the Liard First Nation ("LFN"). Kaiya's death occurred during a COVID-19 outbreak in Watson Lake. Kaiya tested positive for COVID-19 on July 24, 2021 and was still positive at the time of her death.

The Jury's Findings

The Jury found that Kaiya died at Upper Liard on August 1, 2021 at 8:15 am as a result of positional asphyxia. They classified the death as accidental.

Kaiya and her brother were staying with a babysitter in Upper Liard over the July 30, 2021 weekend because her grandmother was too sick with COVID-19 to care for them.

On the night of July 31, her babysitter put her to sleep in the center of an adult queen-sized bed at approximately 9 pm with a pillow beside her, between her and the floor. The bed was positioned against the wall but at an angle so that there was a gap between the bed and the wall. Kaiya was alone in the room and at the opposite end of the hallway from the where the babysitter was sleeping. Kaiya rolled off the bed and became wedged between the mattress and the wall in an upright position with her back to the wall and only the top of her head visible above the bed. The babysitter slept through the night and found her in this position when she woke in the morning. She called for an ambulance at 8:30 am. The ambulance arrived at 8:45 am. The paramedics noted that the baby was unresponsive, not breathing and was pale. They checked for vital signs and found none. One of the paramedics noted she was still warm. They attempted to insert an oropharyngeal airway into Kaiya's mouth, but her jaw was too stiff. They performed CPR until their arrival at Watson Lake Hospital where Dr. Navpaul Rattan took over care. He found no signs of life but continued resuscitation efforts. He officially called the time of death at 9:28 am.

The forensic pathologist, Dr. Elizabeth McKinnon, performed the autopsy on Kaiya. She determined that Kaiya died of positional asphyxiation. She came to this conclusion as a result of her examination and the fact that Kaiya had been found entrapped between the bed and the wall. She testified that the pleural surfaces of Kaiya's lung and thymus and the epicardial surface of her heart had petechial hemorrhages which are consistent with asphyxia. She found no evidence of significant traumatic injuries and no evidence of disease. Although Kaiya tested positive for COVID-19 at the time of her death, Dr. McKinnon explained that you can test positive but not be ill from the disease. She also testified that rigor mortis usually sets in about ½ hour to 1 hour after death beginning in the smaller muscles like those around the mouth. She stated that in someone Kaiya's size, rigor mortis could have set in within ½ hour of death. She also explained that Kaiya's body temperature could have been warm even if rigor mortis had already set in.

The jury heard testimony from Dr. Charmaine Enns, the Medical Officer of Health, North Vancouver Island and Chair of the Island Health Infant Mortality Review. Dr. Enns is an expert in public health and preventive medicine, with a particular focus on safe sleep practices for infants and the causes and prevention of infant deaths. She testified that Kaiya's death was preventable. She stated that infant deaths due to unsafe sleep practices are generally the result of the cumulative impact of multiple risk factors. In Kaiya's case, her age, being placed to sleep in an adult bed, being alone in a room at a distance from anyone else for a prolonged period of time and the placement of blankets or pillows on her side, away from the wall, all contributed to the opportunity for her to become entrapped. The babysitter understood that due to the children's COVID-19 positive status and despite having symptoms of COVID-19 herself, she was supposed to keep her distance from the children. She had reviewed this understanding with a nurse at Yukon Communicable Disease Control who testified that he agreed with her understanding. Dr. Enns testified that there was no medical reason for the babysitter to keep her distance from the baby and this was contrary to safe sleep practices and increased the risk to Kaiya. Dr. Enns also testified that Kaiya was a vulnerable infant because of her background and placing her in a vulnerable household increased the risk to Kaiya. Placement with an alternative caregiver is itself a risk factor; however, the placement of Kaiya at the babysitter's home was a further risk given the babysitter's neurocognition, illness and stress level and other factors, and the lack of adequate instructions and information and the inappropriate sleep space given to the babysitter by FCS social workers.

Recommendation 1:

> *1. To Government of Yukon: Develop an Infant Mortality Review Committee (IMRC) for the Yukon. The IMRC membership should consist of representation from health care providers with an expertise in infant and perinatal health, public health and epidemiology, representation from First Nations community health care providers, the Yukon Coroner's Service, First Nations Child and Family Services if such a program exists, and Government of Yukon Family and Children's Services. While the details of scope, goals and objectives would be determined by the IMRC a specific focus of the committee would be to monitor and review all infant deaths within the territory with a focus on deaths that have a preventable component. The IMRC's finding and recommendations should be made public in order to reduce the likelihood of future deaths with modifiable risk factors.*

The jury received information from Yukon Coroner's Service that between January 2013 and December 2022, twelve infant deaths were investigated in the Yukon, and that eleven of these deaths were determined to be a result of unsafe sleep practices. Six of these infants were First Nations. Dr. Enns testified that these numbers show that the Yukon has a very high rate of infant deaths due to unsafe sleep practices. She testified that there were 4,300 live births between January 2013 and December 2022, making the rate of deaths due to unsafe sleep practices in the Yukon 2.6 out of every 1,000 live births. Dr. Enns compared this to British Columbia where there were 9 deaths for 43,000 live births in 2020 which is a rate of 0.2 deaths because of unsafe sleep practices out of every 1,000 live births. She explained that this means that the Yukon has 13 times the rate of infant deaths due to unsafe sleep practices as does British Columbia. She testified that this is shocking because most infant deaths related to unsafe sleep practices are preventable.

Dr. Enns also testified that the over-representation of Indigenous infants in deaths is not a result of Indigeneity, but due to social determinants of health such as socio-economic status. She explained that the legacy of Canadian policies with respect to Indigenous people resulted in intergenerational trauma and systemic racism which has led to the disproportionate burden of poverty, lack of housing, lack of education, poor access to health care services and unemployment. Dr. Enns further stated that statistics generally under-represent the over-representation of Indigenous infants in deaths as a result of unsafe sleep practices, due to the difficulty in identifying their Indigeneity.

Dr. Charmaine Enns recommended the development of an Infant Mortality Review Committee ("IMRC") for the Yukon because you cannot manage what you do not measure. The IMRC partners would work collaboratively to ensure a culturally safe and appropriate response and ensure that everyone is invested in the outcome.

Recommendations 2 and 8:

> *2. To Government of Yukon: Review the Child and Family Services Act in consultation with First Nations and community partners in order to clarify roles and responsibilities under Extended Family Care Agreements.*
>
> *8. To Family and Children's Services: Create clear policies that apply to Extended Family Care Agreements. These policies should ensure that Extended Family Care Agreement families have a safety plan in place for short-term urgent situations. These policies must outline the roles and responsibilities of Family and Children's Services, extended family caregivers, and people who provide short-term or overnight care for infants.*

The jury heard evidence that the babysitter was a member of the LFN and known to Kaiya's grandmother, but not a close friend. She had babysat for Kaiya and her brother before on three prior occasions, but never overnight. The babysitter's FCS files included the fact that she had spent her childhood in care in various foster homes, had Fetal Alcohol Syndrome Disorder, and that there were child protection concerns when her children were infants. The weekend of July 30, 2021, the babysitter was ill with COVID-19 symptoms and was self-isolating in her home while caring for three children aged 6, 12, and 15. Earlier that year her partner had been removed from her home and was court ordered not to contact her due to a domestic incident.

The jury heard testimony from FCS management that there is currently no policy or legal provision that sets out the role of FCS when a child subject to an EFCA must be cared for by an alternate caregiver. The jury heard testimony that FCS did not believe they were responsible for Kaiya's placement with the babysitter although they made the plan and vetted her by conducting a verbal criminal record check and a child welfare history check. None of the social workers could explain why they took the steps they did at the time. Dr. Enns recommended that the *Child and Family Services Act* be assessed to determine whether FCS's roles and responsibilities under EFCAs are clearly set out or whether there is room for improvement. Dr. Enns noted that policies and procedures flow from legislation.

Recommendation 3:

> *3. To Government of Yukon: Develop legislation to regulate the practice of social work and social workers in Yukon.*

The jury heard evidence about FCS social workers involvement in the events preceding Kaiya's death. Dr. Enns recommended the regulation of social workers in the Yukon. Social work is a regulated profession in all Canadian provinces and the Northwest Territories (NWT). Regulation is beneficial because it allows the regulator to set qualifications and standards for the territory and would allow the Yukon to benefit from the consistency and oversight that the provinces and the NWT currently benefit from.

Recommendation 5:

> *5. To Family and Children's Services: Develop a safe sleep practice policy that:*
>
> a. *Includes up to date information;*
> b. *Explains the reasoning behind various safe sleep practices;*
> c. *Mandates that safe sleep practices information is provided each and every time Family and Children's Services is involved in facilitating the provision of resources, support or financial payment to people who provide short-term or overnight care for infants;*
> d. *Mandates that regional offices maintain a sufficient stock of Health Canada approved safe sleep equipment for use when required;*
> e. *Informs Family and Children's Services employees of the importance of communicating in a manner that takes into account the principles of harm reduction and trauma-informed communication.*

The jury heard evidence from FCS employees and management that at the time of Kaiya's death, FCS had no policy in place to educate and train social workers about safe sleep practices or that mandated that social workers provide information regarding safe sleep practices when leaving an infant in someone's care. The social workers testified that they did not receive any training about safe sleep practices. The social worker who dropped off the bassinet also testified that he did not know the difference between a bassinet and a pack 'n play.

Amongst the risk factors that Dr. Enns identified was the social workers' failure to provide Kaiya's babysitter with clear and unambiguous information that would have made it easy for her to ensure safe sleep for Kaiya. Kaiya's social worker testified that she told the babysitter that Kaiya would not be able to spread her arms out like a starfish in the bassinet but it was doable for one night. She told the babysitter that the bassinet was for Kaiya but did not provide any further instructions or explanation of why Kaiya had to sleep in the bassinet or where the bassinet should be placed. The social worker did not tell the babysitter that Kaiya had fallen off a sofa bed the previous day and EMS attended.

After reviewing the safe sleep policy that was put in place after Kaiya's death, Dr. Enns noted its deficiencies. She also noted the importance of the policy including the "why" which explains the principles of safe sleep in order to empower individuals to make their own decisions and problem solve. The policy lacked an implementation strategy and did not address training or exceptional circumstances including urgent placements like Kaiya's.

The jury also heard testimony from Lucy Barney, a nurse with expertise in the provision of culturally safe health care for Indigenous people. In her testimony Ms. Barney emphasized the importance of the principles of cultural safety, harm reduction and trauma-informed communication underlying communication regarding safe sleep practices.

Recommendation 6:

> *6. To Family and Children's Services: Develop and incorporate policies respecting the stock of safe sleep equipment including:*
>
> *a. staff review and understanding of owner's manuals;*
> *b. staff understanding of the appropriate use of equipment in consideration of the infant's age, size, and weight;*
> *c. owners manuals is provided to the caregiver when equipment is loaned;*
> *d. copies of owners manuals are maintained at the regional office.*

Dr. Enns testified that a bassinet was not an appropriate safe sleep space for Kaiya, a robust 7-month-old child who could move on her own. Kaiya's social worker testified that the bassinet was the only available option for Kaiya. She informed the jury that it was her understanding that Kaiya would need a sleep space for one night and that if she knew the caregiver would require a safe sleep space for a week, she would have done anything in her control to get a more appropriate sleep space for Kaiya. The jury also heard from FCS witnesses that FCS does not have a policy about maintaining a stock of safe sleep spaces.

Recommendation 7:

> *7. To Family and Children's Services: Provide mandatory in-person training on the safe sleep policy every two years for Family and Children's Services employees. This training must be developed using the principles of cultural safety, harm reduction, and trauma-informed communication and should include demonstrations on how to set up safe sleep spaces.*

Dr. Enns suggested that training regarding safe sleep practices should be ongoing. FCS witnesses testified that temporary caregivers were not required to have any education regarding safe sleep practices. Based on her experience working with Indigenous people, Lucy Barney recommended to the jury that all government service providers should be trained regarding how to communicate safe sleep practices in a manner that takes into account the principles of cultural safety, harm reduction and trauma-informed communication.

Recommendation 9:

> *9. Develop a course in collaboration with First Nations that must be completed by every person who is paid by Family and Children's Services to provide short-term or overnight care for infants. This course must include education on safe sleep practices and must be developed using the principles of cultural safety, harm reduction, and trauma-informed communication.*

FCS had no policy in place to educate and train social workers about safe sleep practices or that mandated that social workers provide information regarding safe sleep practices when leaving an infant

in someone's care. FCS witnesses testified that temporary caregivers were not required to have any education regarding safe sleep practices. Lucy Barney recommended that a course be developed that babysitters and respite caregivers must attend that educates them about safe sleep practices. Ms. Barney has experience providing safe-sleep information to Indigenous people and stated that this course must recognize the importance of harm reduction, and educate participants in a manner that is culturally-safe and trauma informed.

Recommendation 10 and 11:

> *10. With a priority for Liard First Nations and Watson Lake, in collaboration with First Nations develop a roster of people in each community that can be relied upon to provide short term or overnight care for infants and children, when a caregiver is in urgent need of such services.*
>
> *11. With a priority for Liard First Nation, support First Nations in the establishment of resources in their communities for the temporary care, including overnight stays, of infants and children in emergency situations.*

FCS witnesses and the LFN Director of Justice testified that it was difficult to find a caregiver for the children at that time because of their COVID-19 positive status, the fact that there was a lot of COVID-19 in the community at the time and the limited number of potential caregivers in town during the summer. FCS identified the babysitter as the only option in the community. If Kaiya and her brother had not stayed with the babysitter, FCS would have had to take the children into temporary care in Whitehorse as there was no placement in Watson Lake.

The jury heard evidence from FCS's Director that some communities are looking to create a roster of potential caregivers that can be relied upon. The jury also heard evidence from the Director of Justice of the LFN that they were working towards creating a local resource to provide emergency temporary care for their community.

Recommendation 12:

> *12. To the Government of Yukon: Consider a public inquiry into the timing and notification of family and caregivers upon Kaiya Stone-Kirk's death, and any appropriate recommendations for improvements for policies and procedures.*

Kaiya was taken by ambulance to the Watson Lake Hospital at 8:45 am on August 1, 2021.

The on-call social worker testified that her weekend was extremely busy and she worked 33 hours between 5:30 pm on July 30 and 11:30 am August 1. Kaiya's babysitter called her at 9:09 am on August 1 and informed her that Kaiya had been taken to the hospital by ambulance. The on-call social worker informed her supervisor at 10:01 am, but neither ever informed the family. At 11:32 am, Kaiya's grandmother contacted FCS herself and was extremely distressed. The on-call social worker testified that she understood because of the conversation that Kaiya had passed away. Kaiya's grandmother testified that she initially learned from her son that one of her grandchildren had passed away, but he did not know which one. The medical staff at Watson Lake Hospital did not know the identity of the baby and the RCMP had to question the babysitter and make further inquiries before identifying Kaiya and notifying her mother at 11:27 am. FCS witnesses did not consider themselves responsible for notifying the family.

A juror asked FCS's Director whether an inquiry into what happened after Kaiya's death would be helpful. She noted that a review of processes is generally helpful but that whether that comes in the form of an inquiry would not be her decision.

Recommendation 13:

> *13. To Family and Children's Services: When Family and Children' Services requires the services of the RCMP that community safety officers be considered where appropriate.*

The on-call social worker testified that if they required assistance in the communities with home checks and a social worker is not available, they ask the RCMP to assist. The Director of FCS was asked if this might be triggering for some clients and if FCS considered using community safety officers instead. The Director responded that they had no formal arrangement to do so.

Presiding Coroner Mara K. Pollock