
INFORMATION BULLETIN

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INNOVATIVE CHILD DEATH REVIEW PROCESS PRODUCES COLLABORATIVE RECOMMENDATIONS

The Chief Coroner, Terry Smith, announced today the completion of an innovative process reviewing the death of 2 year-old Chassidy Amanda Whitford. The Coroner's Judgement of Inquiry, which is available to the public, contains twelve recommendations adopted from a collaborative process which included representatives from Chassidy's family and community and from agencies involved who are interested in preventing similar deaths in the future.

Chassidy died in Mission in August, 2002. Her father was convicted of Criminal Negligence Causing Death in relation to her death and is currently serving a six and a half year sentence.

"The process we followed in Chassidy's case was unique," Smith said. "I am very pleased with the quality of the recommendations that came out of it." The Chief Coroner has responsibility for reviewing children's deaths provincially.

The first step in reviewing Chassidy's death was the local coroner's investigation and the development of an agreed statement of fact. Smith then consulted with family and community members and in April convened a meeting close to Chassidy's community. The meeting included representatives from the Sto:lo Nation, Tribal Council, community elders, the Laq:mel Reserve, Xyolhemeylh Agency, Ministry of Child and Family Development, RCMP, College of Physicians and Surgeons, Fraser Health Region and Crown Counsel. A family member was also invited to attend.

"From an Aboriginal community perspective, it was a respectful and inclusive approach," said Maureen Chapman, Skawahlook First Nation Chief. "We were particularly pleased that it included the voices of the Elders".

Those attending the meeting focused on how all involved, if faced with that same set of circumstances today, could react more effectively in order to prevent a similar outcome in the future.

"The meeting was very moving for everyone," comments Jane Morley, Child and Youth Officer for British Columbia who consulted with the Chief Coroner on the development of the process and who attended the two day meeting. "Chassidy was on everyone's mind as we collaboratively worked on recommendations designed to avoid such tragedies in the future. An added benefit to this process is that the participants are in a position to go back to their respective organizations to champion the recommendations that emerged."

Smith says that he intends to use similar processes in the future when a child's death raises systemic issues that warrant an in-depth case review.

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