Chronology of the Transition of Child Death Review Function Between 2001 and 2003
DRAFT: November 22, 2005

Background

In 2001 Government was undertaking a core services review of all government services and programs. In August 2001, Jane Morley was commissioned by the Ministry of Attorney General and the Ministry of Children and Family Development to assess the core services and programs of the Children's Commission and make recommendations on how these could be provided most effectively. Jane Morley was former counsel to the Gove Commission and well versed in matters relating to children in care and children and youth generally. Her mandate included a review of the responsibilities of the Child, Youth and Family Advocate (CYFA); the Ministry of Children and Family Development (MCFD); the BC Coroner's Service (BCCS) and the Ombudsman to identify potential service overlap and duplication. Morley was also charged with making recommendations about how to address any issues of overlap and duplication.

Morley concluded that having two specialized children's officers is neither efficient nor effective, but that one children's officer would assist government in effectively carrying out its responsibility to children whose families do not have the capacity, in whole or in part, to look after them without government support or intervention. In regard to child fatality reviews, Morley determined that the Children's Commission reviews the circumstances of all children's death and reviews the lives and deaths of more than half of the children who die in order to determine the adequacy of services to the child during the child's life, examining public health and policy matters, and making recommendations. Both the Children's Commission and the Coroner's office review the deaths of all children who die unexpectedly. Both the Children's Commission and MCFD review the deaths of all children who die in the care of MCFD or who have received services from MCFD within 12 months of their death. Morley recommended that the Children's Commission's child fatality review function be discontinued and elements of it be incorporated into the Coroner's Service. The multi-disciplinary team under the Children's Commission should be continued by the Coroner but its membership expanded to include a MCFD representative and a representative from the College of Physicians and Surgeons. She also recommended that MCFD continue its child fatality reviews.

Jane Morley's report was accepted by the Ministries involved and put forward to government for consideration as part of the Ministry of Attorney General's Core Services review.

In February 2002 government decided to implement the Core Services Review recommendation of the Ministry of Attorney General and Ministry of Children and Family Development that the Children's Commission (CC) and Child and Family Youth Advocate (CFYA) be eliminated and that an Office for Children and Youth be created. It was determined that a single agency would be established to monitor services and advocate on behalf of children, youth and their families. In addition, the Coroner's and ombudsman's roles in protecting children should be strengthened. As part of this decision, the BCCS was charged with the responsibility of being the single agency responsible for the investigation of deaths and for the oversight of related activities within the Province of British Columbia.

In early November, 2005, it came to government's attention that some key aspects of the new organizational model may not have been implemented appropriately. In response to this concern, the Deputy Solicitor General was charged with reviewing the events that transpired during the transition to the new organizational model. A key component of the Deputy Solicitor General's work was determining the chronology of events relating to the transition process transferring responsibility for child fatality reviews and related processes from the Children's Commission to the Coroner's Office, the Ministry of Children and Family Development and the Office of the Child and Youth Officer.

The time frame under review spans from August 2001 through to full implementation of the new functions within the B.C. Coroner's Service (BCCS) on January 1, 2003. The mandate was understood to be fact finding.

The information outlined in this chronology has been obtained from a variety of sources including: review of official documents from MAG, electronic files and interviews with key persons involved both in the decision-making processes to move to the new model and those charged with managing the transition. A number of sources of information remain outstanding as this chronology was completed within the constraints of limited time. Some limitations of this chronology are as follows:

- The chronology may not be a complete record of all relevant events. In particular, there is a lot of material that has not been seen or reviewed. CURRENT IDENTIFICATION OF REMAINING FILES TO BE REVIEWED: Review of the electronic and hard files former CC now with CYO; Deputy SG, Deputy AG; Policing and Community Safety Branch HQ

and ADM; Coroner's Services. It may well be that within those files there is information that is relevant and would provide further information or explanation of what currently appears in this chronology.

- It is intended only as a report of information that has been obtained through interviews and preliminary file review. It is not intended to analyse information or suggest conclusions that should be drawn from it. The interviews conducted were in all cases understood in advance to be limited to fact finding. Other than to record it and note where it is corroborated, the information received and files reviewed have not been analyzed. As noted above, there is significantly more information that should be reviewed.

Interviews:

Alison MacPhail, Former Deputy Solicitor General, Currently Deputy Minister, MCFD
Coroner's Staff:
Terry Smith, Chief Coroner
Norm Leibel, Deputy Chief Coroner
Lisa Lapoint, Assistant Deputy Chief Coroner
Tej Sidhu, Policy/Research Analyst
Colin Harris, Coroner, Child Death Review
Beth Larcombe, Coroner, Child Death Review
Jane Morley, Child and Youth Officer
Chris Peterson, Associate Deputy Child and Youth Officer
Tony Heemskirk, Former ADM, Policing and Community Safety, Ministry of Public Safety and Solicitor General (PSSG)
Gillian Wallace, Former Deputy Attorney General
Paul Pallin, Former Children's Commissioner
John Greschner, Former DeputyChildren's Commissioner
Doug Foster, David Galbraith, Treasury Board Staff
Susan Christie, Former Director, Agencies, Board and Commissions Branch, Ministry of Attorney General

Chronology of Appointments to Special Agencies:

Children's Commission
April 30, 1999: John Greschner appointed acting Children's Commissioner (no term)
September 16, 1999: Paul Pallan appointed Children's Commissioner for a six year term
September 30, 2002: Paul Pallan appointed Acting Child and Youth Officer

Coroner's Office
February 26, 2001: Terry Smith is appointed Chief Coroner for a three year term
February 26, 2004: Terry Smith is reappointed Chief Coroner for a five year term

Child and Youth Officer
May 1, 2003: Jane Morley is appointed Child and Youth Officer for a four year term

Passage of Relevant Acts

May 30, 2002: *Office for Children and Youth* Act is passed
September 30, 2002: *Office for Children and Youth Act* is proclaimed

Chronology of Events:

Date		Source
August, 2001	Jane Morley retained by Ministry of Attorney General and Ministry of Children and Families to assess core services and programs of the Children's Commission	Official File (MAG-DM)
December, 2001	Jane Morley's core services review report submitted to Attorney General and Minister for Children and Family Development. Her mandate included a review of the responsibilities of the child, youth and family advocate, the Ministry of Children and Family Development, the BC Coroner's Service and the ombudsman to identify potential service overlap and duplication. Conclusions: • Duplication and overlap exist between agencies that oversee children's	Official File (MAG-DM) Verbatim, Jane Morley's

	programs and services in BC • Having two specialized oversight agencies (CC and CYFA) is neither efficient nor effective and diverts resources away from front-line service delivery by MCFD • Government ministries and agencies should have primary accountability for service delivery. A single agency should be established to monitor services and advocate on behalf of children, youth and their families. The coroner's and ombudsman's roles in protecting children should be strengthened. Recommendations: MCFD • The ministry should be directly and publicly accountable for programs and services delivered to children and youth • The ministry should be responsible for setting standards for service delivery and monitoring adherence to those standards • The ministry's own complain review processes should be improved to resolve service complaints quickly and directly at the local level Children's Officer • The CC and OCYFA should be consolidated into a new agency, the Children's Officer, accountable to the attorney general • The Children's Officer should be an advocate for children, youth and families regarding government services • The Children's Officer (CO) should monitor government services to these groups to ensure they are adequate and if necessary make recommendations to government on how services should be improved • The new CO should conduct special investigations upon request by the attorney general or the minister of children and family development • The CO should work with communities to find ways to ensure that children and families have a stronger voice in how government delivers services BC Coroners Service (BCCS) • The legislated authority of the BCCS to investigate all unexplained, unattended or unexpected deaths – including those of children, should continue • In addition, the service should track and collect data on all children's deaths and, with the help of a multidisciplinary team, identify patterns and make recommendations. Ombudsman The ombudsman's current responsibility to respond to complaints about government services should be enhanced to ensure response to complaints about breaches of children's statutory rights and standards of care and service for children and youth	Report
December 3, 2001	Correspondence from Paul Pallan to Attorney General Geoff Plant advising of four areas where he disagrees with Jane Morley's review. Section 13 (policy advice and recommendations)	Official File (MAG-DM)
January, 2002	Coroner's Office asks the Children's Commission to continue tracking deaths. 416 entries are made in CITAR from January 17, 2002 to March 21, 2003 (334 in 2002, 82 in 2003). No new hard copy files are created for these CITAR entries	Chris Peterson / John Greschner/ Coroner's Staff
January 25, 2002	Document in Ministry of Attorney General Transition Team file created by Susan Christie titled "Oversight of Government Services to Children, Youth and Families. Describes shifts in accountability from Children's Commission to various government agencies. With respect of transfer of files from the Commission to the	Official File (MAG)

	Coroner the following is noted (Excerpt from Page 2): **Fatality Reviews** • Section 13 (policy advice and recommendations) • Section 13 (policy advice and recommendations) • Making recommendations on basis of fatality reviews. Currently CC; Proposed Coroner through Multidisciplinary Teams • Section 13 (policy advice and recommendations) • Investigating all unexpected, unattended, unexplained deaths of children in BC. Currently CC and Coroner's Service; Proposed: Coroners Service • Investigating the deaths of children in care who had received services from MCFD when deaths are not within Coroner's jurisdiction. Currently CC and MCFD; Proposed: MCFD • Convening multidisciplinary team to review child deaths – as appropriate. Currently CC; Proposed: Coroner's Service • Monitoring compliance with recommendations arising from child fatality reviews. Currently CC and Coroner's Service; Proposed: Children's Officer, Coroner's Service • Collecting and monitoring information on child deaths in BC. Currently CC & BC Stats; Proposed: Coroner's Office, BC Stats and Children's Officer	
February 7, 2002	Cabinet approves recommendation that the CC and CFYA be eliminated and some functions transferred to a newly created Office for Children and Youth.	Official File (MAG)
February 13, 2002	Transition Steering Committee in process of being established. Gillian Wallace is the Chair and invites those agencies who will be impacted by the new model to see if they are interested in participating. Minutes of meeting held February 13, 2003 note membership/attendance is as follows: Gillian Wallace (DAG); Jay Chalke (PGT); Susan Christie (MAG staff – Secretary); Chris Haynes, DM MCFD (Janice attended); Howard Kushner (Ombudsman); Laverne MacFadden (A/C &Y Advocate), Gary Martin ED MAG, Paul Pallan (CC); Terry Smith (BCCS) **Information from Official Minutes** • Perry Kendall will be asked to join Transition Team • Draft Terms of Reference: to be revised per discussion and circulated prior to next meeting • Recommendations will address issue of resources and ensure that all expectations for offices discharging functions under the new model are as clear as possible **Excerpts from handwritten meeting notes (G. Wallace)** Confirmation of membership of TT: . . . Howard: "[Terry's] participation on some issues not appropriate – have an interest re implications for his office's mandate – others inappropriate – govt dec'n on logistics/staff Gill: remove yourself if inappropriate; Gill will keep you involved; working groups will deal with staffing • Transitional issues – CYFA – hand off – CO • Gillian: we can identify existing not new resources. Not a cost cutting exercise? Our priority is to set up new office • Gillian: risk of new duties – can it be done without additional resources? • Working Groups: Work Plan: John Greschner/Chris P/Ian Moss/Linda Carlson; Janice; Syd Pilley In process of trying to find any minutes from working group – not in official transition file.	Official File (MAG-DM)
February 27, 2002	Transition Team established comprised of : Gillian Wallace (AG), Jay Chalke (PGT), Chris Haynes (MCFD), Howard Kushner (Ombudsman), Laverne MacFadden (A/C & Y Advocate), Gary Martin (ED MAG), Paul Pallan (CC), Terry Smith (Chief Coroner) and Perry Kendal (CMO) – who joined later	Official File (MAG-DM)

	Minutes of meeting include review of Terms of Reference. Excerpts below: Terms of Reference state: "The transition team is established to provide advice and recommendations to the Attorney General and the Minister for Children and Family Development regarding the establishment of the Children's Officer. . . The team will address: Legislation… Transitional Issues: • Ensure that a plan is in place to manage the closure of complaints/investigations that are in process at this Children's Commission; • Ensure that a plan is in Tribunal Division Members; Ensure that a plan is in place for transition activities of the Advocates Office; • Ensure that a plan is in place to move the fatality review function to the Office of the Chief Coroner; • Ensure that a plan is in place to have the external complain review function done by the Ombudsman's Office; • Ensure that a plan is in place to appropriately dispose of all records of CC and CYFA. Logistics: (excerpt) • Ensure that impacts on other agencies are addressed in transition plans Operational/policy/practice issues: (excerpt) • Nature and scope of multi-agency/multi-disciplinary child death investigation • Recommendation on the future of the Children's Commission database • Critical Incident reporting Official Minutes of Meeting: (excerpt) "Legislation should be permissive rather than prescriptive regarding the activities to be carried out by the new agency. More "mays" than "shalls".	
March 17, 2002	Transition team meeting material includes BN from working group. Prepared by Linda Neville (MAG policy analyst) March 12/02. Transition issue raised: "It has been suggested that there are a number of ways to deal with outstanding fatality reviews: • Section 13 (policy advice and recommendations) • Section 13 (policy advice and recommendations) • Section 13 (policy advice and recommendations) Official Transition Team Meeting Minutes: 11. "Fatality reviews will be completed by the CC up to the cut off date, the remainder will be transferred to the Coroner's Service which will have discretion to complete the reviews and notify families."	Official File (MAG-DM)
May 29, 2002	Letter from Ken Dobell, DM to Premier, to Paul Pallan confirming that Pallan is to take on additional responsibilities relating to the establishment of the new Office for Children and Youth and "ensuring a smooth transition from the existing to new structure."	Official File (MAG-DM)
July 2, 2002	Correspondence from Pallan to Wallace which notes (Excerpt): " I have had preliminary discussions with the Coroners' office and we will transfer files and provide access to the database on a schedule that our two agencies can absorb. . . We will be notifying parents who have responded to letters notifying them of investigations that those investigations will not be completed because of the transition to the new office. These communications will be complete or near complete by the time of the proposed proclamation."	Official File (MAG-DM) Also provided by Chris Peterson (CYO)
July 18, 2002	Correspondence from Terry Smith, Chief Coroner to Tony Heemkserk, ADM, Policy and Community Safety, PSSG that discusses the additional functions that the BCCS will be taking on once the OCYA has been proclaimed. He notes in	Official File (PSR – ADM)

	particular: "As of that date certain responsibilities will devolve to the Coroners Service. In particular, the Coroners Service will become the final reviewing agency for child deaths occurring in British Columbia, for establishing a Child Death Review Protocol and Committee, for the warehousing, manipulation and compilation of statistics relating to child death and all related issues, and for the development of both annual and special reports on child death, its causes, associated problems and possible remedies. To discharge these responsibilities in a full and comprehensive manner will require the acquisition of skilled personnel that are currently not employed by this Service" The correspondence expands upon the new functions and outlines the staffing and budgetary requirements, the objectives to be achieved, and the concise rationale for each. Terry Smith further notes: "While this proposal identifies additional costs to be borne by the Coroners Service, I would point out that it accomplishes largely the same ends as those currently being addressed by the Children's Commission at a fraction of the cost. In developing this proposal we have been careful to identify only those functions that we believe are key and essential. It is our view that the implementation of risk management measures beyond the level identified would represent the assumption of unacceptable risk to children. Additionally, we have been particularly sensitive to public and governmental expectations regarding the high value placed on our youth. Those expectations establish and environment within which there is a high degree of probability that a negative sentiment and public criticism would be quickly generated from any or real perceived lack of vigilance on the part of government and/or . . . BC Coroner's Service. The note identifies are requirement of $415,000 additional funding to fulfill new mandate (with cost breakdown)	

July 22, 2002	E-mail note from Tony Heemskerk to Alison MacPhail (cc Gary Martin, Brigitte Fitzpatrick, Terry Smith, Jim Crone, Arlene McAuley) which states: "Attached find document from terry on the costs associated with child death review. His analysis shows a requirement of $415,000 for 03/04 onward. I think we could reduce this slightly but it is a reasonable level for the task he suggesting he take on. Gary and I have met with Paul who says he has no money to move to the coroner. This budget plan was drawn up when terry's staff met with those at the commissions to clarify the mandate of each agency. If terry takes on the mandate described in the document then the mandate of the office for the children and youth act should be limited. However I believe we need to confirm that this is the mandate that the coroner office should take on. As terry indicates in his note we need to decide that soon as the announcements and decisions regarding the commission are imminent. Some discussion with the minister on this is necessary. If the mandate is acceptable the we have additional pressure on our budget for future years." Attachment July 18 letter from Terry Smith to Tony Heemskerk outlining proposed mandate for coroner and detailed budget. ARCS 280-20	Official File (PSR ADM)
July 22, 2002	Letter to Paul Pallan from Gillian Wallace providing a status update on plans for the transition to the new office for Children and Youth. It notes (excerpts): "I understand you are in discussions with the Chief Coroner regarding the transfer of the child fatality database from the Children's Commission to his office, and future data requirements. When you have completed these discussions I would appreciate a letter confirming that, as required by section 15(1)(d) of the Office for Children and Youth Act, the transfer of all records relating to the investigation of a child's death to the Chief Coroner has taken place."	Official File (MAG-DM)

	NOTE: A letter with this confirmation has not been found in MAG DM official file but a detailed reviewed of the CC files has not yet taken place.	
July 24, 2002	E-mail from Terry Smith to Tony Heemskerk and Alison MacPhail. Subject: "Comparison Matrix for the Devolution of Responsibilities from the Children's Commission". Full text of e-mail: "Tony/Alison, Here is the requested comparison chart providing details on our abilities under the two funding alternatives. Our initial proposal was designed to address what is anticipated to potentially be somewhat of a public and media controversy with the closure of the Children's Commission. Under the "status quo" scenario we would be left to detail our limited monitoring capability which would undoubtedly be compared to what was done. An ancillary consideration was the need to continue to monitor to be able to react appropriately to a situation similar to the Section 22 (personal privacy) case should something similar happen in the future. Hopefully we would still identify such a case however, section 13 (policy advice and/or recommendations). Currently we are on-target to achieve our first year budget reduction target. Further reductions in services will be necessary to meet our second-year target. This will add further pressures in meeting our new child death monitoring acitivities next year as well as our historical activities. I understand that Mr. Pallin's new organization will retain approx. 23 or the previous 43 staff. Are there any possibilities that some negotiations could see a transfer of some of that funding. I remain particularly concerned that we will be unable to meet the expectations of us." Attachment: Matrix of ability to carry out functions with the $415,000 requested compared with a status quo budget. Excerpts from attachment: With Status Quo budget Ongoing Monitoring of all child deaths: "Ability to detect and investigate ONLY the most obvious cases of sudden and unexpected death – as reported by external persons or agencies under the ongoing obligation imposed by the Coroner's Act." Case by case analysis of sudden and unexpected child deaths – as reported by external persons or agencies under the Coroners Act obligations: "Ongoing (but likely increasingly limited in extent and detail as operational budget austerity increases)" Review of Child Deaths by a Specific External Review Team: "Non Existent" Internal review of Child deaths: "Some ad hoc post investigational review of reported child deaths death will continue in a very limited fashion. This will be limited to the deaths monitored i.e. only applicable to those death reported under the Coroners Act. Systemic Topic Related Recommendations for Death Prevention: "Non Existent" Formulation of recommendations on a case-by-base basis: "Ongoing (but likely increasingly limited as operational budget austerity increases)" Specific review of ALL Deaths of Children in Care: Non Existent since Monitoring Function will not exist. Specific Review of ALL Deaths of children in recent receipt of MCFD services: "Non existent since Monitoring Function will not exist"	E-mail provided by Terry Smith

	Production of Topic Related "Special Reports" on Child Death: "Non Existent" Ongoing research into child deaths as a specific capability: "Non Existent"	
September 3, 2002	**Sept. 3:** • Letters go out from John Greschner to parents advising that review of death will not be completed. • In all instances where reviews were started, letters were sent saying no more review and made a reference to the Coroner (reference to Coroner not reflected in template letter provided by CYO). • 85 letters were sent out. The hard copy files are in the group of 466 files sent off site in March 2003. The group of 85 were those parents who indicated a desire to receive the final investigation report. (This information provided by Chris Peterson/John Greschner, Paul Pallan and corroborated by official correspondence from MAG-DM files – CC files have been requested from off site storage to review and confirm but this work has not yet been done).	Copy of letter provided by Chris Peterson
September 30, 2002	• The *Office for Children and Youth Act* is proclaimed. • Office for Children and Youth established and Paul Pallan is appointed as A/Child and Youth Officer by MO 284 effective September 30.	QP Legaleze Official File (MAG-DM)
September 30, 2002	Letter from Gill Wallace to Paul Pallan confirming arrangements regarding his responsibility related to the new Office for Children and Youth. Letter requires him to work with MCFD and MAG to establish mutually agreeable outcomes for the new office and performance measures for himself as Acting CYO. Signed as accepted by Paul Pallan, Oct 2/02. cc: K. Dobell, V. Collins, J. Mochrie, M. McLeod.	Official File (MAG-DM)
October 1, 2002	Letter from Paul Pallan to Gill Wallace regarding Outcomes/Deliverables for Paul Pallan, A/Child and Youth Officer: "I expect to achieve the following outcomes (Excerpt) Get agreement on MOU with Coroner's Office around sharing of information, transfer of files, roles and responsibilities and role of our office on new Multidisciplinary team." NOTE: MOU not on MAG-DM file – need to review CC and Coroners files.	Official File (MAG-DM)
October 23, 2002	Letter from Attorney General Geoff Plant to Paul Pallan acknowledging Paul Pallan's appointment as Acting Child and Youth Officer and noting his term of office began September 30/02.	Official File (MAG-DM)
October 31, 2002	Memo from Susan Christie to Gillian Wallace regarding Paul Pallan's October 1, 2002 Memo to Gillian Wallace (referenced earlier). Excerpts of this correspondence include: "Resources: Paul has been advised by Gary Martin that the resources originally allocated to the new office for this and subsequent years have been or will be reduced to allow the transfer of 2 FTEs and $250,000 to the Office of the Chief Coroner to enable that office to carry out the child and fatality review functions." "Outcomes: • Get agreement on MOU with coroner's office around sharing of information, sharing of files, etc. This area was identified as a priority in your letter to Paul dated July 22/02 where you asked for a specific letter from Paul "confirming that, as required by section 15(1)(d) off the Office of Children and Youth Act, the transfer of all records relating to the investigation of a child's death to the Chief Coroner had taken place." My discussions with the Coroner's office has suggested that work discussions to date have not been very fruitful. I recommend that a very high priority be assigned to this task in your response to Paul and that the wording of the outcome be changed to read:	Official File (MAG-DM)

	Finalize transfer of all records relating to the investigation of a child's death to the Chief Coroner as required by section 15 (1)(d) of the Office for Children and Youth Act."	
November 2, 2002	E-mail from Gillian Wallace to Susan Christie asking her to help write the response to Paul Pallan's Oct 1/02 Memo to Gillian Wallace. She notes (Excerpt): "(5) Outcomes/Coroners Office: I have concern about identifying this as a high priority because I don't want to get into ranking all these priorities for him. If there are issues with the coroner's office, give me more detail and I will talk to Paul about it. . . the development of an MOU would seem to be desirable – finalizing transfer would be in addition to MOU." As noted earlier – MOU not on official MAG-DM file – need to review CC and Coroner's files	Official File (MAG-DM)
November 18, 2002	Memo to Paul Pallan from Gillian Wallace responding to his correspondence of Oct 1/02. Advises budget for OCY to remain the same for the year but allocation for subsequent years will be adjusted to ensure Coroner's Office can carry out its mandate respecting child fatality reviews.	Official File (MAG-DM)
January 1, 2003	Coroner takes over all child death reviews.	Corroborated by Coroner's Office, Paul Pallan, John Greschner, and the data trail
January 17, 2003	• E-mail from Tej Sidhu (coroner's staff) to Chris Peterson (OCY staff) noting "in our last meeting with John [Greschner] it was agreed that the CC would transfer ownership of files in name only – files will remain at your current off-site storage . . . pending investigation files will remain at your office (OCY) and then be transferred to off-site storage. We will not physically see any of the files here.	E-mails received from Chris Peterson

January 17, 2003	Access to three accession files (Children's Commission fatality review files in off site storage) transferred to Coroner's Office. Accession numbers 93-9639, 93-7448 and 94-0950. File lists indicate all files are child fatality case files.	Records Management Tracking System
March 4, 2003	E-mail from Chris Peterson to Tej Sidhu advising pending investigation files will be sent to off-site storage and that costs for the off-site storage area will be coded to Coroner's office E-mail from Tej Sidhu to Chris Peterson confirming the files should go to the off-site in Victoria "as we don't anticipate recalling many of the files."	E-mails received from Chris Peterson
March 12, 2003	• 45 boxes from Children's Commission sent to off site storage (Accession 94-5519). Access rights given to Coroner's Office. File lists indicate all files are child fatality case files. • Chris Peterson notes transfer made in accordance with s. 15(1)(b) and 15(1)(d) of the OCYA. Chris Peterson believes there are 466 files in these boxes (based on a count of the file list). • The 466 files include 12 files that had completed investigation reports that were not released by the CC for various reasons. They were not released by the OCY (s. 15(1)(c)). • 8 boxes of records (61 files) held back by CYO (John) because he wanted to call the families personally (confirmed by John Greschner, Chris Peterson and Jane Morley). NOTE: these files were found to be in the storage area at CYO by Chris Peterson November 15, 2005- E-mail from Chris Peterson to Tej Sidhu	Records Management Tracking System and Chris Peterson e-mail November 15th to Sharon McKinnon (MA-MCFD)
May 1, 2003	• Jane Morley appointed Child and Youth Officer for 4 year term. (OIC 0413 – approved and ordered April 4/03 effective May 1) • Paul Pallan's appointment as Acting Child and Youth Officer is rescinded by	Official File (MAG-DM)

	Ministerial Order M223 (dated April 1/03)	
November 15, 2005	• CYO reports 416 entries made in CITAR for child deaths between January 2002 and March 2003, no hard copy files created. • CYO reports 466 “active” files sent to off site storage. The number 466 comes from a count of the off site file lists done by Chris Peterson. CYO later reports 539 files are listed as “active” in CITAR. • 8 additional boxes of child death investigation records found at the CYO containing 61 files. • CYO reports that 13 files are missing (539-466-61 = 12? RMB review of boxes)	E-mail from Chris Peterson to Sharon McKinnon and Tej Sidhu