CHILD DEATH REVIEW COMMITTEE
ACTIVITY PLAN
2023-26

Message from the Chairperson

This is the Activity Plan for the Child Death Review Committee, outlining the objectives for the fiscal years April 1, 2023 to March 31, 2026.

The Child Death Review Committee is classified as a Category 3 Government entity. As such, it must prepare an activity plan taking into consideration the strategic directions of the Provincial Government as communicated by the Minister of Justice and Public Safety. Those strategic directions have been taken into account.

This plan was prepared under my direction with input from the Committee members and in accordance with the provisions of the **Transparency and Accountability Act.**

As Chairperon of the Child Death Review Committee, I accept accountability on behalf of the Committee for the preparation of this plan and the achievement of its objective.

Catherine Barker Pinsent, MSW, RSW
Chair

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Overview

The Child Death Review Committee (the Committee) is a multi-disciplinary committee established pursuant to section 13.1 of the **Fatalities Investigations Act**. This Committee was formed in March 2014 and comprises seven members, who serve for a term established by the Lieutenant-Governor in Council. As of April 1, 2023, the Committee members were:

- Catherine Barker Pinsent, Chair;
- Donna Ballard, K.C., Vice-Chair;
- Jo Anne Broders;
- Noreen Careen;
- Colleen Fox;
- Dr. Sandra Luscombe;
- Crystal Northcott; and,
- Dr. Nash Denic, the Chief Medical Examiner also serves ex officio.

The Committee meets to review the facts and circumstances of child deaths; deaths occurring during or following pregnancy in circumstances that might reasonably be related to pregnancy; or stillbirths or neonatal deaths where maternal injury has occurred or is suspected. All child deaths investigated by the Chief Medical Examiner require review by the Committee. The reviews involve consideration of facts and information outlined in written reports provided by the Office of the Chief Medical Examiner.

The Child Death Review Committee does not have a separate budget. Expenses are captured under the Administrative and Policy Support activity line within the Department of Justice and Public Safety's budget.

Mandate

The Committee is required to review child deaths, maternal deaths, and stillbirths or neonatal deaths as outlined in the **Fatalities Investigations Act**.

After each review, the Committee shall report to the Minister of Justice and Public Safety on its findings and submit to the Chief Medical Examiner all records relevant to the review. The Committee also monitors trends in these deaths, may make recommendations on identified trends and determines whether further review is necessary or desirable in the public interest. The Child Death Review Committee does not present separate Lines of Business as they are reflected in the Mandate.

Vision

A comprehensive review process that contributes to a reduction in the incidents of preventable child deaths, as well as maternal deaths related to pregnancy.

Strategic Issue

Issue 1: Compliance with the Fatalities Investigations Act

The Committee conducts reviews in accordance with section 13.2 of the **Fatalities Investigation Act**. This includes reviewing the facts and circumstances of child deaths; reviewing deaths occurring during or following pregnancy in circumstances that might reasonably be related to pregnancy; or reviewing stillbirths or neonatal deaths where maternal injury has occurred or is suspected.

All child deaths investigated by the Chief Medical Examiner are reviewed by the Committee. The review process involves an analysis of the facts contained in written reports and investigative material compiled by the Chief Medical Examiner's Office and other reports identified as relevant by the Committee. The Committee prepares a report on its findings and submits the report to the Minister of Justice and Public Safety.

The focus of the Committee will remain consistent over the next three years, and the Committee will report on the results of the following objective during the years 2023-26.

Objective	By March 31 each year, the Child Death Review Committee will have conducted reviews and prepared reports in accordance with the **Fatalities Investigations Act**.
Indicators	• The Child Death Review Committee receives referrals from the Office of the Chief Medical Examiner. • Reviews are assigned by the Chairperson to Committee members to complete reports and submit to the Committee. • The Committee reviews individual reports and determines if recommendations to the Minister of Justice and Public Safety are required. • The Committee submits to the Minister of Justice and Public Safety copies of each child death review and any resulting recommendations. • The Committee identifies trends and risk factors, and submits corresponding recommendations, when appropriate, to the Minister of Justice and Public Safety.