

**CHILD DEATH REVIEW COMMITTEE
ANNUAL REPORT 2024-25**

Message from the Chair

I hereby submit the 2024-25 Annual Report for the Child Death Review Committee (The Committee). The Committee is a Category 3 entity, and this report was prepared under my direction and in accordance with the provisions of the **Transparency and Accountability Act**, for the period of April 1, 2024, to March 31, 2025.

I would like to take this opportunity to acknowledge the work of the Committee members in ensuring that reviews were completed in a respectful and compassionate manner. While this work is often difficult, members feel it is a privilege to serve the children and youth of the province in this capacity. The assistance of the Office of the Chief Medical Examiner and the Department of Justice and Public Safety in their support of the Committee's work has been invaluable.

As Chair of the Committee, I accept accountability for the results reported on behalf of the Committee and for the preparation of this report and the achievement of the objective and indicators.



Catherine Barker Pinsent, MSW, RSW
Chair

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Overview

The Committee is a multi-disciplinary Committee established pursuant to section 13.1(1) of the **Fatalities Investigation Act**. The Committee was first established in March 2014 and is comprised of seven members, who serve for a term established by the Lieutenant-Governor in Council, which is three years. As of March 31, 2025, there were six appointed Committee members and one vacancy.

- Catherine Barker Pinsent, Chair,
- Donna Ballard, K.C., Vice-Chair,
- Jo Anne Broders,
- Noreen Careen,
- Dr. Sandra Luscombe; and,
- Crystal Northcott

The Chief Medical Examiner, Dr. Nebojsa Denic, serves as an ex-officio member of the Committee. The Committee is also supported by the Manager of Corporate Services in the Office of the Chief Medical Examiner.

The Committee meets to review the facts and circumstances of child deaths. A child death is defined as the death of a person under the age of majority whose death is reportable to the Office of the Chief Medical Examiner under the **Fatalities Investigation Act**. In addition, the Committee also investigates maternal deaths which are 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. The reviews involve consideration of the facts and information in the case files with access provided by the Office of the Chief Medical Examiner in addition to supplementary documentation required by the Committee.

As per ongoing practice, consultation with officials and staff of the Department of Justice and Public Safety and other government departments occurs as necessary in relation to policies and procedures. Remuneration for the Board is in accordance with Treasury Board's Guidelines for Rates of Remuneration for Boards, Commissions and Agencies as a Level II board. The 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

In accordance with its Mandate, the Committee is required to review child deaths, maternal deaths, and stillbirths or neonatal deaths as outlined in the **Fatalities Investigation 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 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 incidences of preventable child deaths, as well as maternal deaths related to pregnancy.

Highlights and Accomplishments

The Committee, with the assistance of Office of the Chief Medical Examiner and Department of Justice and Public Safety, started to review and update its administrative processes. The Chair and Manager of the Office of the Chief Medical Examiner reviewed historical and current records to create a digitized database which is accessible to the Chair and Department of Justice and Public Safety. The database is housed with the Office of the Chief Medical Examiner. A working group with representation from the Committee, Office of the Chief Medical Examiner and Department of Justice and Public Safety updated the Committee's Terms of Reference. This is the first review of the Terms of Reference since 2015. Final approval is anticipated in early 2025-26.

Linkages continued to be a priority during 2024-25. The Chair and Vice-Chair continue to meet with the Child and Youth Advocate on a semi-annual basis. The Chair remains as a member of the Morbidity and Mortality Review Committee sponsored by the Society of Obstetricians and Gynecologists of Canada (SOGC). During 2024-25, the Chair was a member of the Maternal Morbidity Summit 2.0 planning committee and presented at their Summit in Edmonton, Alberta in June 2024. The Committee has representation on the advisory committee for the Longitudinal Study on Infants, Children and Youth of Newfoundland and Labrador (BEACON Study). This study aims to determine the epidemiology (health and social indicators) of "children at risk," defined as those placed in alternate care, those with medical complexity, and/or those with developmental and mental health conditions. The results will help identify the necessary health and social services required for infants, children, and youth in Newfoundland and Labrador.

There were four meetings of the Committee during fiscal year 2024-25. This included the annual two-day in-person meeting in September 2024. The Committee was able to review all cases referred by the Chief Medical Examiner in 2024-25 and provide reports

and recommendations to the Minister of Justice and Public Safety in a timely manner. On March 31, 2025, the Committee provided a report to the Minister of Justice and Public Safety on **An Analysis of Infant Deaths (2021-2023)**.

Report on Performance

Issue: Compliance with the Fatalities Investigations Act

The Committee reviews child deaths, monitors trends, and makes recommendations to the Minister of Justice and Public Safety on matters related to the prevention of child deaths, including the need for inquiries. The review process involves an analysis of the facts contained in written reports and investigative material compiled by the Office of the Chief Medical Examiner and other reports identified as relevant by the Committee. The Committee prepares a report on its findings and submits it to the Minister of Justice and Public Safety. The objective for the Committee is consistent for the 2023-26 planning period and the associated indicators will be reported on for each year of the planning period.

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 | Results |
|--|---|
| The Child Death Review Committee receives referrals from the Office of the Chief Medical Examiner. | The Committee received eight referrals from the Office of the Chief Medical Examiner during the 2024-25 fiscal year. |
| Reviews are assigned by the Chairperson to Committee members to complete reports and submit to the Committee. | The Chair of the Committee assigned eight cases for review during the fiscal year 2024-25. All assigned reviews were completed prior to March 31, 2025. |
| The Committee reviews individual reports and determines if recommendations to the Minister of Justice and Public Safety are required. | Of the eight reviews completed by the Committee, it was determined that three recommendations to the Minister of Justice and Public Safety were required. |
| The Committee submits to the Minister of Justice and Public Safety copies of each child death review and any resulting recommendations. | The Committee submitted eight completed case reviews and three recommendations relating to three deaths to the Minister of Justice and Public Safety. |
| The Committee identifies trends and risk factors, and submits corresponding recommendations, when appropriate, to the Minister of Justice and Public Safety. | On March 31, 2025, the Committee forwarded to the Minister of Justice and Public Safety a report: An Analysis of Infant Death Trends 2021-2023 . A recommendation based on this report was made. |

Opportunities and Challenges

Four appointments to the Committee expired in August 2024. Four members were reappointed in November 2024. In March of 2025 there was one resignation leaving a vacancy at the end of the fiscal year. Recruitment will occur in 2025 for a policing representative.

The Committee also continues to support an appointment of a person who can represent the Indigenous populations of Newfoundland and Labrador who has experience advocating on behalf of children. The Committee would value the perspective and experience of a person who can represent the Indigenous populations of Newfoundland and Labrador in fulfilling its mandate.

The Committee continues to ensure that child death reviews are completed in a timely manner. The past year also saw the Committees complete an analysis of trends in Infant deaths for the period 2021-2023. Having developed a database capturing all reviews since 2014, the Committee is more readily able to identify trends and patterns in the deaths of children referred for review by the Office of the Chief Medical Examiner. The Committee will continue to review its work practices to ensure efficiency of its operations,

Financial Statements

The 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.