

CHILD DEATH REVIEW COMMITTEE
ANNUAL REPORT 2025-26

Message from the Chair

I hereby submit the 2025-26 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, 2025, to March 31, 2026.

I would like to take this opportunity to thank my fellow Committee members for their dedication and compassion. While this work is often difficult it is rewarding to serve in this role. 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 continues to be 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

Table of Contents

Message from the Chair	i
Overview	2
Mandate	2
Vision	3
Highlights and Accomplishments	3
Report on Performance	4
Issue: Compliance with the Fatalities Investigations Act	4
Opportunities and Challenges	5
Financial Statements	5

Overview

The Committee is a multi-disciplinary Committee established pursuant to section 13.1(1) of the **Fatalities Investigations 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, 2026, 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
- Crystal Northcott

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

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 Investigations 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 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 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 the OCME and the Department of Justice and Public Safety, continues to review and update its administrative processes. During 2025-2026, the Committee's Terms of Reference was approved and a process chart completed. Updated review forms and Orientation guidelines are currently under development.

Linkages continued to be a priority during 2025-26. 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 Maternal Morbidity and Mortality Review Committee, sponsored by the Society of Obstetricians and Gynecologists of Canada (SOGC). The Committee has representation on the advisory committee for the Longitudinal Study on Infants, Children and Youth of Newfoundland and Labrador (BEACON Study). The Committee consults with departments and agencies as necessary to inform its work.

There were seven meetings of the Committee during fiscal year 2025-26. This included its annual two-day in-person meeting in September 2025. The Committee was able to finalize reviews with reports on 92 percent of the deaths referred by the Chief Medical Examiner in 2025-26 and provide reports and recommendations to the Minister of Justice and Public Safety in a timely manner.

The **Fatalities Investigations Act** mandates the Committee to review the facts and circumstances of referred child/youth deaths. The purpose of these reviews is to identify and monitor trends, determine if further evaluation of those deaths is necessary in the public interest, and provide reports and recommendations to the Minister of Justice and Public Safety.

In accordance with this mandate, the Committee provided the Minister with two reports in 2025-26. On July 7, 2025, the Committee forwarded a **Report on Child/Youth Suicides (2014-2024)**. On March 30, 2026, a **Report on Deaths Resulting from Substance Related Toxicity** was provided. Each of these reports contained recommendations.

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 OCME 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 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.	Thirteen referrals received from the OCME in 2025-26
Reviews are assigned by the Chairperson to Committee members to complete reports and submit to the Committee.	Thirteen reviews assigned to Committee members in 2025-26.
The Committee reviews individual reports and determines if recommendations to the Minister of Justice and Public Safety are required.	Twelve reports completed by the Committee in 2025-26.
The Committee submits to the Minister of Justice and Public Safety copies of each child death review and any resulting recommendations.	Twelve cases completed and submitted to the Minister by March 31, 2026. Five cases reviewed contained recommendations.
The Committee identifies trends and risk factors, and submits corresponding recommendations, when appropriate, to the Minister of Justice and Public Safety.	Two trend reports completed with recommendations in 2025-26.

Opportunities and Challenges

The Committee experienced several membership-related challenges during 2025-26. Three appointments to the Committee expired in February 2026. One position, the police investigator, has been vacant since March 2025. Given the specific roles members of the Committee must possess, it can be challenging to identify appropriate candidates. The Committee continues to work with the Department of Justice and Public Safety to address any outstanding appointments.

The Committee also continues to support an appointment of a person who can represent the Indigenous populations of Newfoundland and Labrador with 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 Committee complete two trend reports.

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.