CHILD DEATH REVIEW COMMITTEE
ACTIVITY PLAN
2020-2023

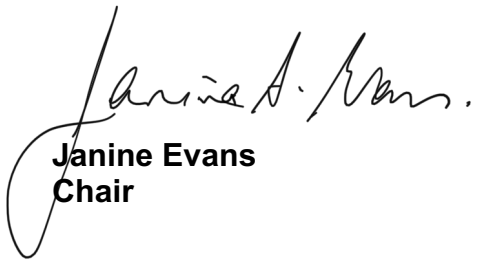
Message from the Chairperson

This is the Activity Plan for the Child Death Review Committee, outlining the objectives for the fiscal years April 1, 2020 to March 31, 2023.

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 chairperson 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.



Janine Evans
Chair

Table of Contents

Overview

The Child Death Review Committee (the "Committee") is a multi-disciplinary committee established pursuant to the 13.1(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, 2020, the Committee members were:

- Ms. Janine Evans (Chairperson)
- Ms. Anna Katic Duffy (Vice-Chairperson)
- Ms. Michelle Chislett Lahey
- Dr. Stephen Lee
- Ms. Judy Voisey
- Insp. Sharon Warren
- Ms. Carol Ann Caines
- Dr. Nash Denic (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 occurs or is suspected. All child deaths investigated by the Chief Medical Examiner are reviewed by the Committee. The reviews involve consideration of facts and information outlined in written reports.

The Child Death Review Committee does not have a separate budget. Expenses are captured under Administrative and Policy Support Activity Line within the Department of Justice and Public Safety Budget.

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 Child Death Review Committee does not present separate Lines of Business as they are reflected in the Mandate.

Values

The discussions and decisions of the Committee will be guided by the following values:

- **Integrity:** All members act within their areas of expertise and are reliable in their interactions with Committee colleagues.
- **Collaboration:** All members contribute to discussions and consider the views and contributions of their colleagues in reaching decisions and forming recommendations.
- **Impartiality:** All members approach each review without bias.

- **Empathy:** All members consider the potential impact on the families of deceased children when completing reports and making recommendations.
- **Accountability:** All members acknowledge and respond to their accountability to the Minister of Justice.
- **Fairness:** All members consider all facts and information presented to them.
- **Confidentiality:** All members keep all reports and discussions confidential.

Primary Clients

The Committee makes recommendations to promote the health, safety and well-being of children and pregnant women.

Vision

A comprehensive review process that contributes to a reduction in the incidence of preventable child deaths.

Strategic Issue

Issue 1: Compliance with the Fatalities Investigations Act

The Committee will review child deaths, maternal deaths, and stillbirths or neonatal deaths as outlined in the **Fatalities Investigation Act**; monitor trends; and make recommendations to the Minister of Justice and Public Safety on matters related to the prevention of child deaths, maternal deaths, and stillbirths or neonatal deaths, including the need for inquiries. The review process will involve 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 will prepare a report on its findings and submit the report to the Minister.

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 2020-23.

Objective	By March 31 each year, the Child Death Review Committee will have reviewed child deaths, maternal deaths, and stillbirths or neonatal deaths in accordance with the **Fatalities Investigations Act**.
Indicators	• Meetings held as required to review child deaths referred from the Office of the Chief Medical Examiner • Submitted a report to the Minister on each child death review • Child death review records are submitted to the Chief Medical Examiner • Child deaths reviewed collectively to identify trends, risk factors and recommendations for the prevention of child deaths • Recommendations from collective reviews are submitted to the Minister