Child Death Review Committee

Annual Report 2014-15

Message from the Chairperson

I am pleased to submit the 2014-15 annual report for the Child Death Review Committee. This is the first report for this committee and was prepared under my direction with input from the committee members and in accordance with the provisions of the *Transparency and Accountability Act*.

This first year of the committee's operation required focus on developing procedures, policies, forms and communication mechanisms to facilitate the functions of the committee. This development work was informed by consultations with the Department of Justice and Public Safety officials and staff, the Child and Youth Advocate, and the Minister and Executive of the Department of Child, Youth and Family Services. The committee began reviewing cases in Fall 2014, at which time the Office of the Chief Medical Examiner had several cases ready for consideration by the committee.

As chairperson of the Child Death Review Committee, I accept accountability on behalf of the entire committee for the content of this report and actual results reported.

Ellen Oliver MSW, RSW
Chairperson

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Overview

The Child Death Review Committee is a multi-disciplinary committee established pursuant to the *Fatalities Investigations Act*. This committee was first appointed in March 2014 and has eight members. The committee members, who are appointed for three year terms, are:

Ms. Ellen Oliver (Chairperson)
Ms. Janine Evans (Vice Chairperson)
Dr. Simon Avis (Ex-Officio)
Ms. Lorraine Burrage
Ms. Noreen Careen
Insp. Barry Constantine
Dr. Victoria Crosbie
Dr. Robert Morris

The committee meets monthly if there are child deaths to review. 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.

Mandate

The mandate of the Child Death Review Committee is contained in the *Fatalities Investigations Act*. The committee is required to review the facts and circumstances of child deaths, including stillbirths and neonatal deaths. The committee is also required to review maternal deaths during or following pregnancy in circumstances that might reasonably be related to pregnancy.

The committee monitors trends in these deaths and determines whether further evaluation is necessary or desirable in the public interest. After each review, the committee shall report to the Minister on its findings and submit to the Chief Medical Examiner all records relevant to the review.

Vision

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

Highlights/Accomplishments

In addition to the work reported in the Report on Performance section of this report, the committee also completed work associated with the formation of a new committee.

An important aspect of the committee's work is to ensure that the Child and Youth Advocate is regularly updated regarding cases under review. The committee worked with the Child and Youth Advocate on the development of a communications strategy to ensure the timely sharing of required information.

The Chairperson of the Child Death Review Committee is responsible for advising the Child and Youth Advocate of cases under review, as well as the dates for reports submitted to the Minister.

Additionally, a Memorandum of Understanding (MOU) was signed between the Chief Medical Examiner and the Department of Child, Youth and Family Services (CYFS). This MOU enables CYFS to share information when a child case under review by the committee has had previous involvement with CYFS.

This ensures that the Child Death Review Committee has comprehensive information in such cases to inform its reviews.

Report on Performance

Issue: Compliance with the *Fatalities Investigations Act*

This committee was appointed in March 2014 and held its first meeting on May 15, 2014. The first meeting and a meeting on June 19 focused on the development of procedures, policies, forms and processes that would ensure the efficient functioning of the committee.

During the fiscal year, a total of four committee meetings were held to review the deaths of seven children. These meetings occurred on October, 23, 2014 and January 22, February 26, and March 26 in 2015. The committee submitted five reports to the Minister of Justice and Public Safety. The two remaining reports were not finalized by the end of the fiscal year but will be submitted to the Minister in April 2015.

Recommendations were made in five of the seven cases. The number of cases eligible for review, and the fact that they occurred for a variety of causes, precluded collective analysis that could identify trends.

Additionally, the committee clarified its role with respect to maternal deaths during the fiscal year. This clarification is reflected in the mandate on page 1 of this report. There were no cases of maternal deaths presented for review in 2014-15.

The focus of the Child Death Review Committee will remain consistent over the next two years, and the committee will report on the results of the following objective, measures and indicators in 2015-16 and 2016-17. It will also report on any maternal deaths reviewed by the committee in these years.

Objective: By March 31, each year, the Child Death Review Committee will have reviewed child deaths in accordance with the *Fatalities Investigations Act*.

Measure: Child deaths reviewed in accordance with the *Fatalities Investigations Act.*

Indicators	Results
Meetings held as required to review child deaths referred from the Office of the Chief Medical Examiner.	The Office of the Chief Medical Examiner referred seven child deaths during the fiscal year. Four meetings of the committee were held to review these cases.
A report on each child death review is submitted to the Minister.	Five reports were completed and submitted to the Minister during the 2014-15 fiscal year. The reports for the two additional matters were not concluded by the end of the fiscal year. These reports will be reflected in the 2015-16 annual report of the committee.
Child death review records are submitted to the Chief Medical Examiner.	Copies of all child death review records were submitted to the Chief Medical Examiner.
Child deaths reviewed collectively to identify trends, risk factors and recommendations for the prevention of child deaths.	The seven deaths reviewed by the committee varied in manner and cause of death, which precluded the identification of trends, risk factors and broad recommendations.
Recommendations from collective reviews are submitted to the Minister.	There were no recommendations from collective reviews, and therefore, no submission of collective recommendations to the Minister.

Opportunities and Challenges Ahead

The existence of the committee is in and of itself an opportunity. It represents the potential to achieve a better understanding of the factors influencing neonatal, child and maternal deaths. The broad scope of the committee enables collection of data which will identify trends that will lead to prevention strategies. The steps involved in collecting and disseminating data and developing strategies will forge interdepartmental and interagency collaborations which can improve collective action.

The committee has identified an opportunity to enhance the information currently collected and filed by Medical Examiners. The Chief Medical Examiner currently seeks the broadest information attainable under the *Fatalities Investigations Act*, however, there is room to improve the level of detail surrounding government department and service agency system involvement in each case. The committee is identifying areas where more information would be helpful as it reviews each case. It plans to assess the need for additional information and discuss any findings with Department of Justice and Public Safety officials.

The area of maternal deaths is another opportunity for system enhancements. Currently, there are very low numbers of maternal deaths reported to the Office of the Chief Medical Examiner and it is possible that they are under reported. The committee will engage in further discussion and consultation to identify recommendations aimed at ensuring that reportable deaths are referred to the Office of the Medical Examiner.

The reviews conducted by the committee will continually identify the type and quality of information that is most useful in identifying risks and opportunities for prevention of child and maternal deaths. The discoveries of the committee will be shared with investigators and health professionals to enhance investigative tools that support the work of the committee and ultimately inform professional practices.

Financial Report

The Child Death Review Committee does not have a separate budget. Expenses are captured under Administrative Support within the Department of Justice and Public Safety Budget. In fiscal year 2014-15, the Committee expenditures totaled approximately $3,713.