Child Death Review Committee

Annual Report 2015-16

Message from the Chairperson

I am pleased to submit the 2015-16 annual report for the Child Death Review Committee. This is the second report for this Committee, which is a category 3 entity, 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 past year the Committee focused primarily on case reviews. Several procedures were also revised to improve efficiency. Consultation with officials and staff of the Department of Justice and Public Safety and other government departments occurred as necessary in relation to cases and procedures.

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. At March 31, 2016, 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

The Committee reviewed cases at each meeting during this reporting period and provided reports to the Minister in accordance with procedures. The details of this work are reported in the performance section. In addition to this work, the Committee continued to build capacity in navigating government structures. A listing of key contacts within government departments was generated to facilitate collection of information relevant to recommendation development.

The Child Death Review Committee engaged with employees of the Labrador and Aboriginal Affairs Office to identify consultants representing Innu and Inuit communities. These consultants will be engaged if there is a death of an Aboriginal child, to ensure the cultural context is considered with respect to such cases.

A preliminary trend tracking system was created to assist the Committee in its analysis. The Committee will work towards enhancing this tracking system in the next fiscal year.

The Committee also designed two report guidelines to be used by the Department of Child Youth and Family Services when there is a death of a child who had involvement with CYFS.

Report on Performance

Issue: Compliance with the *Fatalities Investigations Act*

The Committee met regularly and reported on each case. Several cases required discussion at more than one meeting since additional information was required and obtained after the initial discussion. There was also a delay in reporting on a number of cases while consultation occurred in regard to reporting on cases that were under active police investigation.

The focus of the Child Death Review Committee will remain consistent over the next year, and the Committee will report on the results of the following objective, measure and indicators in 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.	Nine meetings were held during the fiscal year to review 16 deaths referred from the Office of the Chief Medical Examiner.
A report on each child death review is submitted to the Minister.	Sixteen cases were reviewed and 15 reports sent to the Minister of Justice and Public Safety; four of these relate to cases which were reviewed in 2014-15; 10 of the reports included recommendations. Four of the cases reviewed in 2015-16 were still under consideration by the Committee at year end and these reports will be submitted in 2016-17.
Child death review records are submitted to the Chief Medical Examiner.	Fifteen child death review records were submitted to the Medical Examiner's office. The remaining report will be submitted in fiscal year 2016-17.
Child deaths reviewed collectively to identify trends, risk factors and recommendations for the prevention of child deaths.	A total of 16 child deaths were reviewed in 2015-16. The child deaths are being reviewed collectively to identify trends, risk factors and recommendations for the prevention of child deaths. A number of trends are beginning to emerge and further analysis will occur in 2016-17 to determine recommendations that can be made for the prevention of child deaths.
Recommendations from collective reviews are submitted to the Minister.	Recommendations from collective reviews were not submitted, as the number and type of cases did not allow for such conclusions to be drawn. Analysis was ongoing at the end of the fiscal year, and recommendation will be submitted to the Minister when appropriate to do so.

Opportunities and Challenges Ahead

The Committee has now been operational for two years. As the Committee works through operational issues, establishes new procedures, and reviews more child deaths, it is beginning to identify emerging trends. This is an opportunity for the Committee to make concrete recommendations to government departments that will guide them on how to address preventable child deaths.

The Committee will continue to work with various stakeholders to achieve continuous improvement in its operations and to obtain all the information it requires in fulfilling its mandate.

Financial Statements

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.