CHILD DEATH REVIEW COMMITTEE
ANNUAL REPORT 2020-21

Message from the Chairperson

I am pleased to submit the 2020-21 Annual Report for the Child Death Review 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**.

As per ongoing practice, 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 Committee for the preparation of this report and the achievement of its objective.

Janine Evans
Chair

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Overview

The Child Death Review Committee (CDRC) is a multi-disciplinary committee established pursuant to subsection 13.1(1) of the **Fatalities Investigations Act**. This CDRC was formed in March 2014 and comprises seven members, who serve for a term established by the Lieutenant-Governor in Council, and the Chief Medical Examiner. During fiscal year 2020-21, the CDRC 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 CDRC 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 occurred or is suspected. All child deaths investigated by the Chief Medical Examiner are reviewed by the CDRC. The reviews involve consideration of facts and information outlined in written reports.

The CDRC does not have a separate budget. Expenses are captured under Administrative and Policy Support activity line within the budget of the Department of Justice and Public Safety.

Mandate

The CDRC is required to review child deaths, maternal deaths, and stillbirths or neonatal deaths as outlined in the **Fatalities Investigation Act**.

After each review, the CDRC 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 CDRC 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.

Highlights

During fiscal year 2020-21, the CDRC met twice to review child deaths in accordance with its mandate. Meetings were limited during 2020-21 due to the ongoing COVID-19 global pandemic. The Chair communicated as required with the Office of the Child and Youth Advocate.

The CDRC forwarded three reports to the Minister of Justice and Public Safety on December 3, 2020, that included recommendations. The reports examine the facts and circumstances surrounding deaths of children and youth in Newfoundland and Labrador that occurred between 2014 and 2020. Under section 13.5 of the **Fatalities Investigations Act**, the Minister of Justice and Public Safety is required, within 60 days after receiving a report from the CDRC, to make public those recommendations relating to:

- Relevant protocols, policies and procedures;
- Standards and legislation;
- Linkages and coordination of services; and
- Improvements to services affecting children and pregnant women.

The recommendations were made public on February 1, 2021 and the reports were forwarded to the Child and Youth Advocate.

Report on Performance

Issue: Compliance with the Fatalities Investigations Act
The Child Death Review Committee reviews child deaths, monitors trends and makes recommendations to the Minister 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 CDRC. The CDRC prepares a report on its findings and submits it to the Minister. The objective for the CDRC is consistent for the 2020-2023 planning period and the associated indicators will be reported on for each year of the planning period.

Objective: By March 31, 2021, the Child Death Review Committee will have reviewed child deaths 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 CDRC held two meetings during 2020-21. One meeting was held in October 2020 and another November 2020.
Submitted a report to the Minister on each child death review	The CDRC submitted fourteen death reports to the Minister in December 2020. The reports examine the facts and circumstances surrounding deaths of children and youth in Newfoundland and Labrador that occurred between 2014 and 2020.

Child death review records are submitted to the Chief Medical Examiner	Fourteen child death review reports were submitted to the Office of the Chief Medical Examiner during the fiscal year. A report was submitted for each one.
Child deaths reviewed collectively to identify trends, risk factors and recommendations for the prevention of child deaths	Child deaths are reviewed collectively to identify trends and risk factors on an ongoing basis. These trends inform recommendations for the prevention of child deaths. Since March 2014, 81 deaths have been analyzed and reported.
Recommendations from collective reviews are submitted to the Minister	The CDRC submitted foutreen reports to the Minister in December 2020. Of these reports, three reports resulted in recommendations to the Minister of Justice and Public Safety.

Opportunities and Challenges

The Child Death Review Committee faces specific challenges but these also presents unique opportunities. During 2020-21, the current appointment terms for the existing members ended. Recruitment of new members presents a unique challenge for the CDRC, as members must be highly skilled professionals, including a physician with experience in pediatrics, a social worker, a police officer, a lawyer, a nurse, an advocate of women, children and youth, and an educator with experience in the kindergarten to grade 12-school system. It is important to ensure that the members of the CDRC have the professional skills and experiences to conduct the work of the CDRC. New membership provides an opportunity for a fresh perspective on the work of the CDRC, as well as presenting members with an opportunity for inter-professional collaboration. Recruitment for new members was initiated in 2020-21 and is ongoing.

Financial Statements

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.