Child Death Review Committee

Activity Plan 2014 - 17

Message from the Chairperson

I am pleased to present the Activity Plan for the Child Death Review Committee which outlines the objective for the fiscal years April 1, 2014 to March 31, 2017.

The Child Death Review Committee is classified as a Category 3 Government entity and, as such, must prepare an activity plan taking into consideration the strategic directions of the Provincial Government as communicated by the Minister of Justice. Those strategic directions have been taken into account and it has been determined that none are applicable to the work of the Committee at this time.

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 entire Committee for the preparation of this plan and the achievement of its objective.

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 newly formed in March 2014 and has eight members. The Committee members, who are appointed for a three year term, are:

Ms. Ellen Oliver (Chairperson)
Ms. Janine Evans (Vice Chairperson)
Dr. Simon Avis
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 will 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,* Chapter F-6.1, SNL 1995. The Committee is required to review the facts and circumstances of child deaths, including stillbirths and neonatal deaths.

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 all review records to the Chief Medical Examiner.

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.

Mission Statement

It is not appropriate for the Child Death Review Committee to adopt the Mission Statement of the Department of Justice given its mandate. The Departmental Mission Statement is focused on work of the Department of Justice and the Child Death Review Committee does not have a direct role at this time. The Committee has not developed its own mission statement in this planning cycle as to do so would be redundant of the objective in the current activity plan.

Issue: Compliance with the *Fatalities Investigations Act*

The Child Death Review Committee will review child deaths, monitor trends and make recommendations to the Minister on matters related to the prevention of child 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 Child Death Review Committee will remain consistent over the next three years, and the Committee will report on the results of the following objective in 2014-15, 2015-16 and 2016-17.

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

- Meetings held as required to review child deaths referred from the Office of the Chief Medical Examiner
- A report on each child death review is submitted to the Minister
- 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