# Child Death Review Committee

Annual Report 2017-18

## Message from the Chairperson

I am pleased to submit the 2017-18 annual report for the Child Death Review Committee. This 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**.

Membership of the previous Child Death Review Committee expired in March 2017. New members were appointed through the merit-based appointments process in November 2017. All members were new appointments, with the exception of the chairperson, who previously served as vice-chair of Committee. An orientation was held for the new members and committee work resumed in January 2018, with approximately five cases reviewed per month since that time to address a backlog of cases.

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 entire Committee for the content of this report and actual results reported.

**Janine Evans**
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 formed in March 2014 and comprises seven members, who serve for a term established by the Lieutenant-Governor in Council. During fiscal year 2017-18, the Committee members were:

Ms. Janine Evans (Chairperson)
Ms. Anna Katic Duffy (Vice-Chairperson)
Dr. Simon Avis (Ex-Officio)
Ms. Michelle Chislett Lahey
Dr. Stephen Lee
Ms. Judy Voisey
Insp. Sharon Warren

## Highlights

During the fiscal year, the Chairperson and Vice-Chairperson of the Child Death Review Committee met with officials of the Office of the Child and Youth Advocate to discuss open and effective communication processes between both groups to ensure timely and confidential information sharing regarding child deaths. This new process enhances the ability of both groups to address concerns related to child safety in a more timely and efficient manner.

Additionally, an enhanced process for communication and information sharing between committee members and with the Office of the Chief Medical Examiner was established. The Chairperson of the Child Death Review Committee worked with Information Management staff of the Department of Justice and Public Safety and the Office of the Chief Information Officer to implement a web-based, secure file transfer system. This has proven to be an effective, secure and efficient means of communication to date.

## Report on Performance

### 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.

**Objective:** By March 31, 2018, 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. | There was a gap in time between meetings to review child deaths this fiscal year, due to the lack of a quorum as a result of the expiration and resignations of past members. The committee held meetings monthly since January 2018. |
| A report on each child death review is submitted to the Minister. | By the end of the fiscal year, 6 reports were in progress and anticipated to be completed and submitted in April 2018. |
| Child death review records are submitted to the Chief Medical Examiner. | All child death review records will be submitted to the Chief Medical Examiner, once the reports are completed. |
| 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. Based on the current number of files to be reviewed, it is anticipated that trends and recommendations will be submitted by Fall 2018. |
| Recommendations from collective reviews are submitted to the Minister. | Recommendations from the collective reviews were not ready for submission to the Minister by the end of the fiscal year. They are anticipated to be submitted early in fiscal year 2018-19. |

## Opportunities and Challenges Ahead

New membership provides an opportunity for a fresh perspective on the work of the Child Death Review Committee. As with any new membership, there is a period of learning and orientation in order to begin working at full capacity.

A priority for the upcoming fiscal year will be to enhance data tracking methods for the Committee. This will provide an opportunity to create efficiencies in data analysis and reporting, as the current manual process is very time consuming. This will create efficiencies in the tracking and analysis of trends from the inception of the Committee in 2014, as well.

At the end of the fiscal year, the Committee had begun discussions with the Department of Justice and Public Safety regarding enhancements to tracking responses to the recommendations it makes in its reports. This will provide an opportunity for the Committee to ensure accountability, as well as to reflect on whether its approach is effective in carrying out 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.