CHILD DEATH REVIEW COMMITTEE

ANNUAL REPORT 2023-24

Message from the Chair

I hereby submit the 2023-24 Annual Report for the Child Death Review Committee (The 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**, for the period of April 1, 2023 to March 31, 2024. As Chair of the Committee I would like to take this opportunity to acknowledge the work of the Committee members in ensuring that reviews were completed in a timely and compassionate manner. I would also like to thank the Office of the Chief Medical Examiner (OCME) and the Department of Justice and Public Safety (JPS) for their support of the Committee's work.

I feel it is important to acknowledge that 2024 is the tenth anniversary of the first meeting of the Committee. During the past decade Committee members have worked diligently to ensure all reviews were completed in a respectful manner with the goal of identifying trends and recommendations that might prevent future deaths. This work is often difficult but also very rewarding.

As chair of the Committee, I accept accountability for the results reported on behalf of the Committee and for the preparation of this report and the achievement of its objective.

Catherine Barker Pinsent, MSW, RSW
Chair

Table of Contents

Overview

The Committee is a multi-disciplinary Committee established pursuant to section 13.1(1) of the **Fatalities Investigation Act**. The Committee was first established in March 2014 and is comprised of seven members, who serve for a term established by the Lieutenant-Governor in Council, which is three years. As of March 31, 2024, there were seven appointed Committee members:

- Catherine Barker Pinsent, Chair;
- Donna Ballard, K.C., Vice-Chair;
- Jo Anne Broders;
- Noreen Careen;
- Colleen Fox;
- Dr. Sandra Luscombe; and,
- Crystal Northcott.

The Chief Medical Examiner, Dr. Nebojsa Denic, serves as an ex-officio member of the Committee. The Committee is also supported by Adam Fitzpatrick, Manager of Corporate Services in the OCME.

The Committee meets to review the facts and circumstances of child deaths. A child death is defined as the death of a person under the age of majority whose death is reportable to the OCME under the **Fatalities Investigation Act**. In addition, the Committee also investigates maternal deaths which are 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. The reviews involve consideration of the facts and information in the case files with access provided by the Office of the Chief Medical Examiner in addition to supplementary documentation required by the Committee.

As per ongoing practice, consultation with officials and staff of JPS and other government departments occurs as necessary in relation to cases and procedures.

The Committee does not have a separate budget. Expenses are captured under the Administrative and Policy Support Activity Line within JPS's Budget.

Mandate

In accordance with its Mandate, the Committee is required to review child deaths, maternal deaths, and stillbirths or neonatal deaths as outlined in the **Fatalities Investigation Act**.

After each review, the Committee 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 Committee 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. The Committee does not present separate Lines of Business as they are reflected in the Mandate.

Vision

A comprehensive review process that contributes to a reduction in the incidences of preventable child deaths, as well as maternal deaths related to pregnancy.

Highlights and Accomplishments

The most significant challenge facing the Committee was resolved with the filling of three vacancies in March of 2023. Orientation of these members occurred in April of 2023. An additional seven meetings in the fiscal year were held. Quorum was achieved at all scheduled meetings which is reflective of the members' commitment. In June of 2023, the Committee had its first in-person two-day meeting. This allowed members who normally attend virtually to meet face to face with their colleagues, OCME and JPS officials.

2023-24 saw the reestablishment of linkages with traditional partners of the Child Death Review Committee. The chair and vice chair met twice with the Child and Youth Advocate and the Director of Individual Advocacy and Investigations. Meetings will continue to occur semi-annually. Meetings with officials of the Department of Children, Seniors and Social Development (CSSD) occurred during the year, At the Committee's March 2024 meeting officials from the Department's Quality Management and Training Division provided an overview of CSSD's programs.

The chair continues to participate in quarterly Maternal Morbidity and Mortality Review Committee meetings hosted by the Society of Obstetricians and Gynecologists of Canada (SOGC)

The Committee was able to review all backlogged cases from previous years and as of the end of the 2023-24 fiscal year all deaths referred by the Chief Medical Examiner were completed and reported to the Minister.

Report on Performance

Issue: Compliance with the Fatalities Investigations Act
The 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 OCME and other reports identified as relevant by the Committee. The Committee prepares a report on its findings and submits it to the Minister of JPS. The objective for the Committee is consistent for the 2023-26 planning period and the associated indicators will be reported on for each year of the planning period.

Objective: By March 31, 2024, the Child Death Review Committee will have reviewed child deaths, maternal deaths, and stillbirths or neonatal deaths in accordance with the **Fatalities Investigations Act**.

Indicators	Results
The Child Death Review Committee receives referrals from the Office of the Chief Medical Examiner.	The Child Death Review Committee received 14 referrals from the OCME during the 2023-24 fiscal year.
Reviews are assigned by the Chairperson to Committee members to complete reports and submit to the Committee.	The chair assigned 18 cases for review during fiscal year 2023-24 (four cases were referred by the OCME in 2022-23) All reviews were completed prior to the end of the fiscal year.
The Committee reviews individual reports and determines if recommendations to the Minister of Justice and Public Safety are required.	The Committee completed 25 reviews in 2023-24 and determined that five recommendations to the Minister of JPS were required (seven reviews were initiated prior to April 1, 2024).
The Committee submits to the Minister of Justice and Public Safety copies of each child death review and any resulting recommendations.	The Committee submitted 25 reviews and five recommendations relating to eight deaths to the Minister of JPS.
The Committee identifies trends and risk factors, and submits corresponding recommendations, when appropriate, to the Minister of Justice and Public Safety.	An analysis of deaths by drowning reviewed by the Committee since 2014 was completed. There were no identified trends to report, and a copy of the review was forwarded to the Minister JPS.

Opportunities and Challenges
Due to recruitment and retention issues, the Committee operated without full membership from the previous fiscal year. Appointments of three members (lawyer, pediatrician, and K-12 teacher) in March of 2023 enabled the committee to complete its work with a broadened interdisciplinary perspective. Orientation of the new members occurred in April 2023.

Recruitment will occur in 2024-25 as four appointments will expire in August of 2024. The positions to be filled are a social worker, nurse, police officer, and advocate.

Full membership is critical to the Committee's work. The chair and JPS have initated a review of board profiles for the recruitment process.

The Committee also continues to support an appointment of a person who can represent the Indigenous populations of Newfoundland and Labrador who has experience advocating on behalf of children. The Committee would value the perspective and experience of a person who can represent the Indigenous populations of Newfoundland and Labrador in fulfilling its mandate.

The focus of the Committee has been to ensure that all child death reviews are completed in a timely manner. The impact of the COVID-19 pandemic resulted in a number of reviews being delayed. The chair is pleased to advise that all child deaths referred to the Committee as of March 31, 2024, have been completed and reported to the Minister. The Committee is now in an excellent position to examine its own procedures to ensure efficiency and effectiveness to benefit future reviews. Given that 2024 is the tenth anniversary of the appointment of the first Committee such reflection is appropriate.

Financial Statements
The Committee does not have a separate budget. Expenses are captured under the Administrative and Policy Support Activity within JPS.