CHILD DEATH AND CRITICAL INJURY REVIEW

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Introduction

This report examines the varying internal and external processes used in British Columbia, other provinces, the United States and other countries to review child deaths among children and youth. In particular the paper will examine child death review as well as critical injury review for those children and youth who are in care and/or had been receiving services from the Ministry of Children and Family Development within the preceding year at the time of the incident.

In Canada and in British Columbia in particular, the regular and formal review of the deaths and critical injuries of children is a more recent development than in other jurisdictions. In the United States child death reviews began in some states in the late 1970s. The Los Angeles Child Death Team began when a small group of professionals from child welfare, health, and law enforcement came together in 1978 to examine unexplained deaths of children. They believed that insights into these tragic events could be better provided through co-ordinated efforts and expertise rather than working, as before, as individual investigators. The Los Angeles Child Death Team also believed that the knowledge of the events leading up to and surrounding these deaths should inform and could improve prevention strategies as well as child welfare service delivery.

In British Columbia when the Gove Inquiry (1995) proposed a dedicated child death and critical injury review process, the concept was very new to Canada. Today, however, in every Canadian jurisdiction that has responsibility for the delivery of services, the reporting of child deaths and critical injuries for children in care and children being served is required by the appropriate child welfare agencies. We will recount British Columbia experience in child death and critical injury review, and end with some observations on the current situation.

Child Death Review

Child death review (CDR) has generally focused on “unexpected, suspicious and accidental” deaths of children and youth. Some jurisdictions now include all child and youth deaths. The usual purpose of CDR is to establish the cause of death through a forensic investigative process. Such investigations may avoid a broader examination of the life of the child or the role of the child welfare system unless there is evidence linking agency work to the child’s death.

Using this process agencies have become better able to understand how and why children die and how this can be prevented. This has enabled agencies to focus their efforts on the prevention of child deaths whether through homicide, suicide, drowning, automobile accidents, or fire. No matter how the death occurs, in BC as in other jurisdictions, there is now a mechanism in place to investigate the death.

Child death reviews assess both individual and aggregated cases, the latter to enable the team to identify trends and causes of death and to develop recommendations to prevent future similar deaths from occurring. Some jurisdictions have both individual and aggregate models in place, although many are moving away from individual reviews to focus on identifying trends from aggregate data analysis. These systemic reviews often involve subject matter experts and multidisciplinary teams.

Child Death Review Teams in the US

As noted above, the first Child Death Review Team (CDRT) was formed in 1978 under the Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN), followed by Oregon and North Carolina.[1, 2] Child Death Review Teams focus initially on suspicious or unknown causes of death. The intent of the investigation is to determine if child abuse or neglect has been committed. Increasingly, however, child death reviews focus on preventing child and youth deaths at an aggregate level as opposed to individual investigations.[3]

As Child Death Review Teams expanded across the United States, several studies by experts in the field were able to conclude that child death reviews were effective. In 1995, a national Advisory Board on Child Abuse and Neglect released *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*. This study concluded that CDRTs may "offer the greatest hope of finding the underlying nature and scope of fatalities from child abuse and neglect as well as a means to prevent these tragic deaths".[4]

The National Center on Child Fatality Review (NCFR, 2005) is a United States national resource for anyone involved in child fatality reviews. The information on this site provides information on the benefits of multidisciplinary teams, legislation supporting CDRT and the funding necessary for the CDRT to operate effectively. The NCFR website at http://ican-ncfr.org/ provides a clearinghouse for the collection and dissemination of information and resources related to child deaths. The NCFR is dedicated to providing training and technical assistance to child death review teams throughout the world.

Recurring Themes from US Child Death Review Teams

Research on child death review teams in the United States has been conducted by:

- Alcalde & Elster (2002) Child Fatality Review in the United States:
- A National Overview.

[1] Durfee & Tilton-Durfee, (1995).
[2] Association of State and Territorial Health Officials, (2004).
[3] Hutchins et al (2004).
[4] US Department of Health. (1995).

- National MCH Center for Child Death Review (2005) (an ongoing research project).
- Webster et al (2003). Child Death Review: The State of the Nations
- Bunting & Reid (2005). Reviewing Child Deaths – learning from the American Experience.

Webster, et al. (2003) in their review of Child Death Review Teams in the United States found that:

- 48 states and the District of Columbia have an active CDR program.
- 94% of programs agreed that identifying the cause of and preventing future deaths are important purposes of the CDR.
- 27% of the states identified that assistance with child maltreatment prosecution was as an important purpose
- 45% of the states review deaths from all causes,
- 12% of the states review only deaths due to child maltreatment.
- CDR legislation exists in 33 states.
- 53% of the CDR programs were implemented since 1996, and
- 59% report no or inadequate funding.
- CDR contributes to the death investigation process in 14% of cases

From the other studies, the literature suggests that child death review teams have the potential to

- Decrease misclassification of deaths;
- Increase effectiveness of intervention strategies with surviving children;
- Conduct a systematic review of agency actions (and inactions); and
- Support children and family members who have witnessed the death of a child.[5]

Researchers were also able to identify the following contributing factors that promoted successful outcomes in the team approach to Child Death Reviews:

- The primary focus of CDRT is to investigate all child deaths and make recommendations that could prevent future deaths;
- Consultations with diverse disciplines in law enforcement, social services, and health care take place;
- CDRT members include subject experts who are knowledgeable about the type of death and specific age groups involved;
- CDRT members concentrate on developing prevention measures that are based on aggregate data collected from multiple cases;
- The CDRT works at the community level focusing on trends and local issues in that community;
- CDRT issues annual reports outlining their processes, findings, recommendations, and organizational challenges;
- Teams had legislative authority specifically naming and managing the child death review process; and

[5] Webster et al. (2003), Durfree & Gellert (1992), and Durfee & Tilton-Durfee (1995)

- Legal mandates situate CDRTs in public health departments to ensure they are focused on injury prevention, and do not serve as extensions of the adversarial process.

Other Jurisdictions

The Child Death Review Team model has been implemented in Australia and New Zealand; and has been proposed as a model in England, Scotland, Ireland, and Wales. Other countries have child death processes on an individual case basis such as Israel or Belgium, or part of an agency response specifically focused on child death as in Germany and South Africa.[6]

England

England is currently working on a protocol to implement a national child death review process. The project is due to end December, 2006 with data analysis conducted on a sample of every third child death case. Based on the findings of this pilot, England may begin the process of designing a new child death review process or continue using existing child death data collected through NICE[7].

Supporting documentation by the Working Group convened by the Royal College of Pathologists and Royal College of Pediatrics and Child Health indicates that healthcare professionals are the intended leaders. The new system proposed for England will include minimum certification, pathologists with specialties in pediatrics, and a case management model based on the Avon and Somerset Protocol.[8,9]

Scotland

In Scotland, the modernization of the Coroners Service has resulted in 17 recommendations and identified further research needs[10]. One of the key findings from Scotland's consultation with international experts is the recognition that child protection cannot be a responsibility of specifically dedicated services. The wider system of welfare and universal provision has a crucial influence on the nature of the child protection system and its capacity to respond to the needs of children and families.

Based on this initial research by Scotland's Executive, it was concluded that any changes to the child protection system must address children who are perceived to be at continued risk of harm, siblings of those children killed, children living in dangerous situations, or where criminal proceedings have faltered. Towards this

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[6] A review of current state child death models see Axford and Bullock (2005) study for the Scottish Executive, titled: Child Death and Significant Care Reviews: International Approaches.
[7] Weindling, (2003).
[8] Kennedy, (2004).
[9] Avon and Somerset protocol Multi Agency Public Protection Arrangements (MAPPA) is a process for developing agreements between stakeholder and service providers to ensure that everyone involved in a multi agency response is clear about their duties and responsibilities during each phase of the response.
[10] Scottish Executive, (2004).

goal, Scotland began in 2002 to research and make recommendations to improve child protection. Pilot projects in Aberdeen, Glasgow and Dumfries and Galloway are to develop ways to share multi-agency information for integrated assessment and summary care records, to develop a national set of training models for all people who are responsible for child protection, and to consult with the public on a range of issues associated with child protection.

The new system is intended to be needs as well as evidence-based; matching the needs of children and families; focused on specific local communities; and based on accurate epidemiological data showing prevailing and associated risk factors. It intends as well to foster improved multi-agency cooperation.

Australia

In Australia, child death review share the same characteristics as child death review in the United States. Australia also has two Child and Youth Commissions, with similar mandates to BC's former Children's Commission.

The Commission for Children and Young People and Child Guardian in Queensland, reviews child deaths on a case by case basis for all child deaths of children who were known to the Department of Child Safety within three years of their deaths. The Department of Child Safety has six months to complete and file a report to the Child Death Case Review Committee. The Child Death Case Review Committee then has three months to report on the death to the Director General of the Department of Child Safety. The Committee can ask Director General for progress reports on the implementation of the recommendations. Three functions are being phased into the review process: a systemic monitoring unit, a child death research unit, and a child death register. The Child Death Case Review Committee has aboriginal members who provide the necessary cultural perspective on aboriginal child deaths.

The New South Wales Commission for Children and Young People examines all child deaths, including natural, accidental and suspicious incidents. It conducts trend analysis and specialized research from its findings to develop recommendations for evidence-based prevention strategies.

In Australia, two other important activities in regards to child death review might be noted:

- the Victorian Child Death Review Committee (VCDRC) found that aboriginal cultural concerns at the time of death were not adequately addressed and are implementing aboriginal-specific coroner and child death review practices[11]; and
- Australia's National Coroner's Information System (NCIS) has been successfully used to monitor national trends of child deaths[12].

[11] Victorian (Australia) Child Death Review Committee. (2005).
[12] Driscoll et al. (2003).

Child Death Review in Canada

In Canada, while child death examination can be traced back to 1921, the first Child Death Review Team was created in 1992 in Manitoba.[13] The Manitoba Provincial Advisory Committee on Child Abuse (PACCA) includes a multidisciplinary team consisting of members from:

- Winnipeg Police Service Child Abuse Unit
- RCMP
- Child Protection Centre
- Department of Family Services
- Pediatric pathologist, a pediatrician representing the College of Physicians and Surgeons,
- Crown Attorney, and
- Child and Family Services Advisor from the Assembly of Manitoba Chiefs[14]

The original focus of the Manitoba team was to advise the Chief Medical Examiner (CME) whether an inquest was necessary. The team has moved beyond this role and reviews all aspects of all children's deaths and conducts individual reviews on specific cases. This move toward multidisciplinary review teams or committees has arisen across Canada as coroners and medical examiners, child advocates, police and child welfare professionals look for ways to meet public demands for accountability and effectiveness in service[15].

While there is a general move towards multidisciplinary teams there remains many challenges. Canadian research has found that provincial and territorial child death reviews have evolved very differently. This evolution has resulted in lack of common definitions, misclassification of child deaths and the absence of reliable and consistently reported statistics on child deaths.[16] The first national study conducted in 1999 demonstrated the diversity of child death review systems and the challenge of trying to capture consistent child death information (see Table 1).

[13] BC Coroner Service, Child Death Review, 2004, p.3
[14] Christianson-Wood & Murray, 1999, p. 28
[15] Christianson-Wood & Murray, 1999, p.19
[16] ibid

Table 1 Child Death Review Teams in Canada (1999).

Functions	BC	Alberta	Sask.	Manitoba	Ontario	Quebec	N. Scotia	N. Brunswick	P.E.I	Nfld.	Yukon	NWT
Multi-disciplinary child death reviews	Yes	No	Yes	Yes	Yes	Yes	Yes[1]	Yes[1]	X	No	No	Yes
Legislative mandate for review process	Yes	n/a	Yes	No	No	No	No[2]	No[2]	X	n/a	n/a	No
Case review function	Yes	n/a	Yes	Yes	Yes	Yes	No	Yes	X	n/a	n/a	Yes
Policy development	No	n/a	Yes[3]	No	No	No	Yes[4]	Yes	X	n/a	n/a	u/k
Provincial/Territorial child welfare membership	No	n/a	Yes	Yes	No[5]	Yes	Yes	No	X	n/a	n/a	Yes
Recommendations released case by case	Yes	n/a	Yes	No	No	No	No	Yes	X	n/a	n/a	No
Annual Report release of recommendations	Yes	n/a	Yes	Yes	Yes	No	Yes[6]	u/k	X	n/a	n/a	No

[1] Formed in 1998
[2] Ministerial terms of reference
[3] Separate committee
[4] Preparing for future case review committee
[5] Ont. Assoc. of Children's Aid Societies involved
[6] Future release
X No reponse received at time of printing

Source: Christianson-Wood, J., & Murray, J.L., (1999). *Child Death Reviews and Child Mortality Data Collection in Canada.*

Models for CDR continue to vary across the country. Since the early 1990s, the external examination of unexplained or unusual child deaths in Alberta, Saskatchewan and Manitoba is carried out by the Advocate's Offices, following the conclusion of the coroner and police investigation. Between late 1996 and the beginning of 2002, in British Columbia the Children's Commission reviewed all child deaths and investigated ones that were unusual, unexplained or where the child was in care (irrespective of cause). In addition the Commission reviewed critical injuries of children in care.

Within each province and territory, a mechanism is in place to review internally deaths of children receiving services or in care from the child serving agency. In most Canadian jurisdictions these reviews occur when a child dies unexpectedly in suspicious or unusual circumstances. However, there is no consistent collection of this information across the country nor our results of reviews posted or shared amongst the Directors of Child Welfare. There was agreement last year at the national directors' table that data on deaths and serious injuries should be collected and used as a national outcome measure along with nine others to form the National Outcome Measures Project.

Child death has been investigated by different agencies with varying mandates. As Canada evolved so has the country's ability to monitor infant and child

mortality and injuries. Today Canada has one of the best child survival rates in the world[17].

Child Death Review in British Columbia

Child death reviews in British Columbia have been performed in three distinct periods over the past 10 years:

- Pre Gove (pre 1996)
- Post Gove and during the Children's Commission (1996 – 2002;
- Post Core Review (2003 to the present).

Each period evolved from the previous one and attempted to remedy the challenges within each preceding model.

In reviewing these periods it should be remembered that the Coroners Service always had, and continues to have, the responsibility to investigate all unexpected, suspicious and accidental deaths of children as directed under Sec. 9 of the *Coroners Act*. It was not until September 30, 2002, that its role was expanded to review all child and youth deaths. This will be discussed further below when describing the changes that took place after the closure of the Children's Commission.

Pre Gove Before 1996: The Ministry of Social Services

In British Columbia when notified of a child's death or critical injury, the Superintendent of the Ministry of Social Services had to decide whether the circumstances were suspicious or unusual. If they were, ministry policy required that the superintendent refer the case to the Inspections and Standard Unit (ISU) later Audit and Review Division (ARD) for a case review. Ministry social work staff were also required to notify the Superintendent of the death of a child in care, irrespective of the cause. Not all of the children in care deaths were reviewed. The usual practice was only to refer the suspicious or unusual ones to ISU/ARD. However, decisions by the Superintendent to refer deaths of children to ISU were made inconsistently. When a decision was made to conduct a review it was done by specialized staff in ISU/ARD. The scope of the review was generally limited to the practices and services provided by the Ministry and whether or not the actions of staff were commiserate with policy and legislation. During this time for those unexpected, unexplained child deaths, the Coroner continued to conduct an investigation according to Section 9 of the Coroners Act.

During the Gove Inquiry, an audit team identified shortcomings in the Ministry's review process:

- Criteria regarding when to conduct a review were inconsistently applied.

[17] Statistics Canada. (2005). Selected Mortality Statistics, Canada 1921–1990. 1994 — Catalogue 82-548. Statistics Canada.

- Between 1992 and 1994, conduct of reviews was suspended by the then Superintendent.
- A child death review could be ended at anytime, but documentation pertaining to who ordered the termination, or on what grounds, was not available.
- Reviews took too long to complete, averaging 129 days in spite of the ministry's policy of 60 days.
- Constant changing of reports by Inspectors through a mediated process with field staff and senior management compromised the integrity and public accountability of the review process.

Gove recommended that the ministry's internal review process should be set out in legislation and that the function should be independent from the daily operation of the ministry.

The Gove Inquiry also noted that in those cases where recommendations made by the Coroners Service to the Ministry, the Ministry did not always follow or act on them. During the summer of 1996, following revelations regarding more child deaths of children served by the ministry (or in care) in the legislature, a new child death review process was recommended and implemented by government that was similar to the evolving United States child death review model.[18]

1996 to 2002: The Children's Commission

In September 1996, the Children's Commission was established. The Children's Commission mandate was broader than that recommended by Gove. The new Commission's role was to review all child deaths and investigate the deaths of children in care and those being served, particularly where the death occurred in unusual or suspicious circumstances.

The Children's Commission was an independent agency that reported to government through the Attorney General. The Children's Commission reviewed the circumstances of *all* children's deaths and in approximately a third investigated in some depth the lives and deaths of all children who died. The Commission sought to determine the adequacy of services provided to the child during the child's life, examine public health and policy matters, and make recommendations to enhance the safety and protection of other children. Sometimes the reviews expanded to include the lives of the child's parents, especially if the parents had themselves been in care in the past.

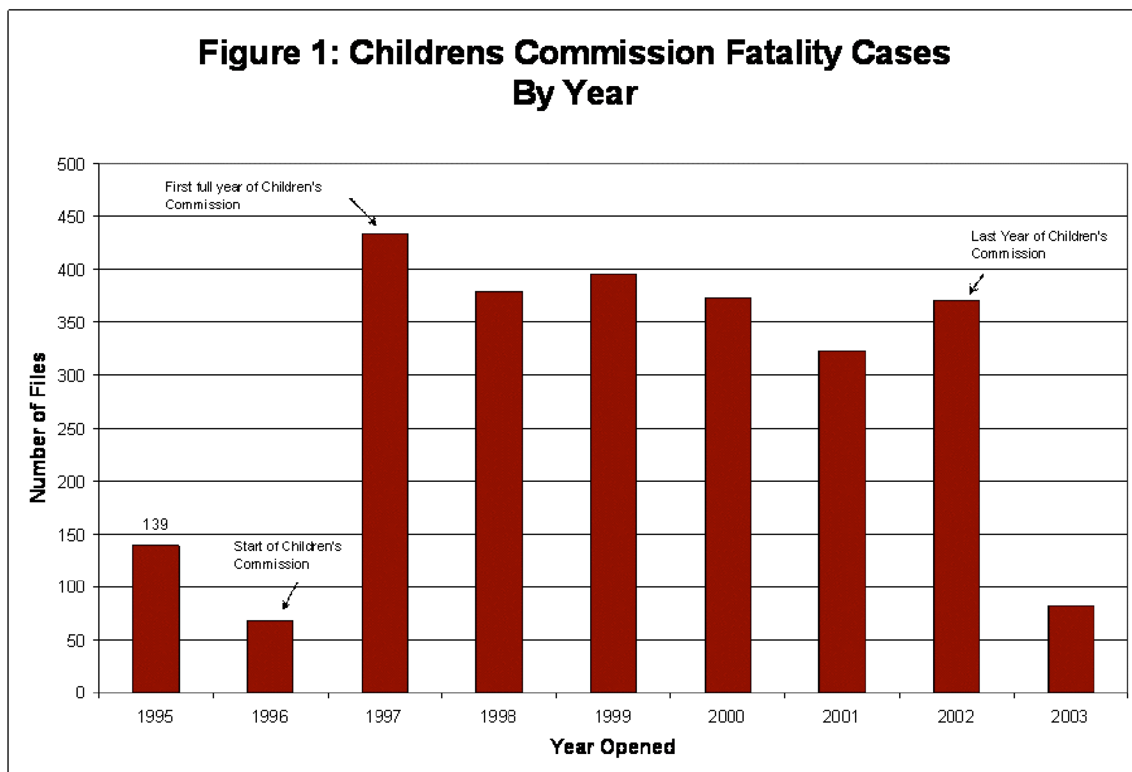
The Commission established a multidisciplinary team that reviewed draft child fatality reports. The team included representatives from the Coroners Service, the Deputy Advocate, the Deputy Provincial Public Health Officer, a paediatric specialist from the Children's Hospital, and other individuals with specialized experience and knowledge of the issues. The multidisciplinary team provided

[18] Durfee & Gellert. (1992).

input into the reports as well as direction for avenues of further investigation prior to the report being concluded. The MDT developed recommendations that were incorporated into the final reports. The Commission tracked these recommendations and the agencies' responses to them.

During this time the Coroner continued his traditional investigative role into all unexpected, unexplained child deaths. During its tenure the Children's Commission completed 780 child death reviews, and reported out publicly on their findings for 769 of these deaths. The Children's Commission was seen by some to be a pioneer in child death reviews, and as a possible model for other jurisdictions looking for improvements to their own child welfare programs.[19]

Figure 1 shows the number of Children's Commission fatality cases by year, beginning with 1995 when 30 deaths were referred by the Gove Inquiry in addition to a number of deaths associated with the Ministry for that year.



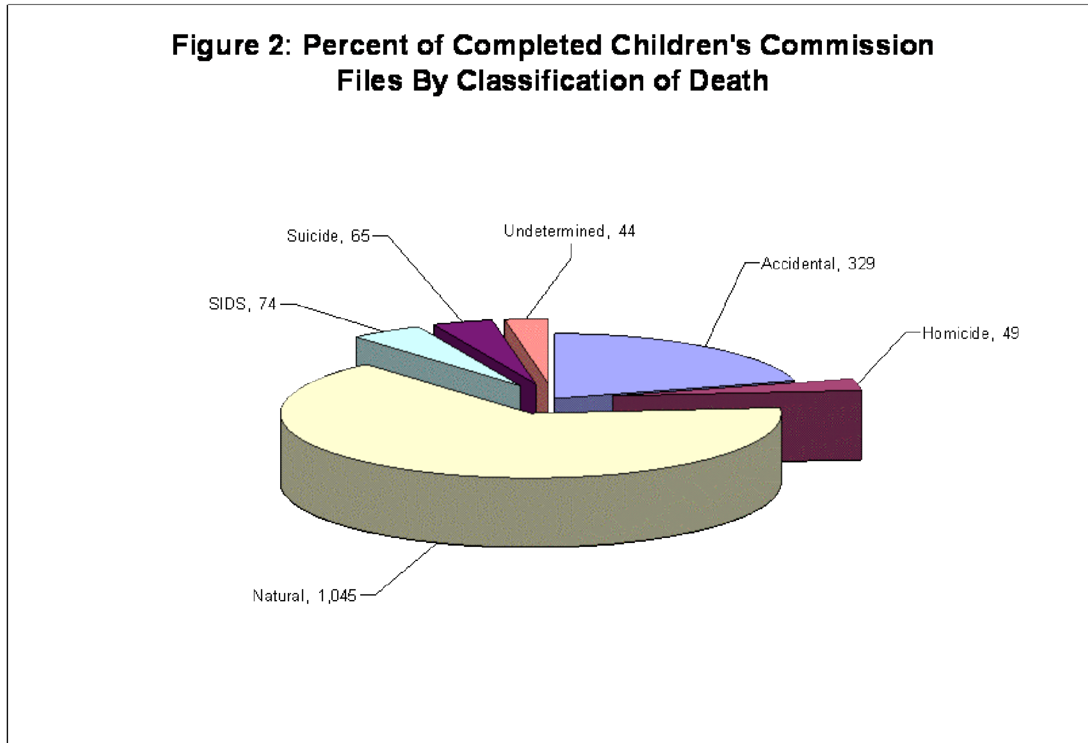
Source: Child and Youth Officer for BC – CITAR Database

Although the Children's Commission began reviewing and investigating child and youth deaths in the fall of 1996, its first full year of operation was 1997. After January 17, 2002, no new investigations were assigned for investigation although cases continued to be recorded in the CITAR database. The Children's

[19] Hall, M. (1998).

Commission ceased operations on September 30, 2002, when the Child and Youth Officer (CYO) was established. The CYO, as a courtesy to the Coroners Service, continued to record child deaths in the database until March 21, 2003.

Figure 2 shows that most deaths studied by the Children's Commission were natural or accidental.



Source: Child and Youth Officer for BC – CITAR Database

During the Commission's tenure 2,563 child deaths were recorded on their database. Of these 1,319 (51%) were assigned to a Commission investigator to review and/or investigate further. Of these 32% required no investigation as the deaths were attributable to natural causes. Of the 1,319 investigations assigned, 780 investigations were completed. When the Commission closed 539 child death files were at some stage of review or investigation. These 539 incomplete child death investigation files and the 416 child deaths recorded on the Children's Commission database have been identified as the 955 transition cases. The issues associated with these cases are discussed in another report.

In the fall of 2001, a core services review was undertaken to determine whether the services of several oversight agencies that included the Children's Commission, the Child, Youth and Family Advocate Office, the Public Guardian and Trustee, the Ombudsman and the Coroners Service might be provided more effectively and efficiently. The review examined the responsibilities of all these public bodies as well as the internal review system of the Ministry of Child and

Family Development (the Ministry) to identify possible areas of overlap and duplication. This review resulted in a number of recommendations to government.

Among other things, the review recommended that the Children's Commission and the Child, Youth and Family Advocate be disbanded, and that an Office for Children and Youth be established. The child death review function should be transferred to the Coroners Service as well as the multi disciplinary team. The ministry would continue its internal child death and injury review function. The new Child and Youth Officer would collect and monitor statistical information on child deaths, and could conduct further investigations based on that information.

Ministry of Children and Family Development (1996 – 2003)

During this period, the Ministry improved its own internal child death review process. The *Reportable Circumstances* policy introduced in 1995 to manage the report of and response to staff within the Ministry of deaths, critical injuries and serious incidents associated with children in care or children receiving services continued to provide policy direction for these incidents. This policy required that staff at every level of the Ministry respond to reported deaths and critical injuries within a specified time frame. This was a change from the earlier policy that required only the reporting of the incident, with no further requirement as to how these reports would be managed. The new policy required that the Superintendent (later Director) determine whether a further review should occur, and that the field staff be advised of this decision. The directive also required a consistent course of action in response to these incidents, which included:

- Gathering additional information to understand the circumstances of the incident, a critical injury or death, more clearly,
- Engaging in case consultation between the Superintendent's Office, senior managers, and field staff regarding family members and surviving siblings to determine whether outstanding child safety issues needed immediate attention, and
- Deciding whether a more formal review of the case was required.

Decisions as to what kind of a review should be conducted into a child's death have also evolved over time. In 1996, all child deaths were reviewed at an initial level. This required the collection of reports and essential file documents to determine if a further, more in-depth review was needed. This first step was done for all reported child deaths between 1996 and 1998. During 1998 and 1999 reviews came to focus more on those unexpected and unexplained deaths where children had died in suspicious and unusual circumstances.

These changes resulted in a more prescribed methodology for reviews, and two distinct levels of review emerged. One was a Deputy Director's Review which

was primarily a document (case file) review, and the second a Director's Case Review, or a full review, that included an examination of all relevant files, and interviews with staff, other service providers, and family members. The scope, terms of reference, and methodology were determined by the provincial Director and case review manager in concert with regional senior managers. Upon completion of a full review, a report was provided to the provincial Director for recommendation development with regional senior managers, and then to the Executive Audit and Review Committee (an interdisciplinary group from all program areas) which made further recommendations prior to final sign off by the provincial Director.

During this period, the Quality Assurance Branch (with a staff of 24) managed a number of responsibilities to support the provincial Director such as, but not limited to, setting competencies for, administering and granting of delegation to new social workers; developing audit tools and conducting provincial audits; managing and reviewing reports on critical injuries and deaths; conducting several hundred reviews Tracking and monitoring these incidents as well as recommendations from the reviews was another key function.

Significant devolution of responsibilities to the regions in just these areas took place in the period 2002-2003. Major quality assurance responsibilities transferred included delegation, conduct of audits and reviews and clinical consultation for (and management of) the *Reportable Circumstances* policy. Each region received approximately one or two FTEs and/or a provincial employee through transfer. Most regions had to reconfigure staff to assume management their regional quality assurance responsibilities

During the period 2002 to 2004, the Ministry's overall budget was reduced by 11% but over half in some headquarters areas. Most of the administrative staff assigned to various program areas, regionally and provincially, were lost. When the regions became responsible for quality assurance they had fewer resources than the former Quality Assurance Branch had enjoyed, notwithstanding the transfer of some headquarters staff to the regions to carry out these responsibilities.

Following devolution of the role of Director, Child Welfare in 2002 and the workforce adjustment in October, 2003, the headquarters role in quality assurance was minimal (there were no changes in the Aboriginal Services Branch). When the Quality Assurance Branch was closed, there was no provincial case review capacity remaining in headquarters. Ongoing quality assurance support was reduced to three staff members who provided delegation expertise and advice to the regions and the aboriginal agencies under the *Child, Family and Community Service Act,* new audit tools for both regions and aboriginal agencies, and clinical consultation and information on high profile cases.

2003 to the Present

In BC, during this period, two agencies had a role in child death review, the Coroners Service, including its Child Death Review Unit (CDRU) and the regional internal review process within each region of the Ministry. In 2005, the Child and Youth Officer began to develop a process to track the ministry's reviews of child deaths and conceptualize a role for itself regarding monitoring of the ministry's child death review process for service delivery improvements and organizational learning.

The following sections outline the present role and responsibilities of each of these organizations.

The Coroners Service

The Coroners Service continues to provide an independent, objective investigation to determine the deceased person's identity, and when, where, how and by what manner a person died. The mandate for child death investigations remains essentially the same as for all other deaths reported to the Coroner.

The first step is the reporting of a child's death.
A child's death is reported to the Coroner by a physician or by the police. An investigation is started beginning with a scene investigation (when there is a scene to attend) and an examination of the body. The names and birthdates of the parents are recorded so that a search can be done with respect to whether there is a record with the Ministry for Children and Family Development and access to their services if required. This preliminary information is reviewed by the Coroner and the Regional Coroner. The purpose of this review is to determine the next steps in the investigation and to determine whether there is a need for autopsy.

Next, the Kimble is created and sent to headquarters. The Kimble is an initial intake form that outlines the preliminary circumstances of death. Kimbles are also forward to the Ministry. This all occurs within 24 hours of the death. If the child's caregivers are available at the time of the death, the Coroner speaks with them and collects information required for the Child Death Protocol (form). Information from the scene investigation will also be included in the Child Death Protocol.

The second step is the investigation of the death.
If an autopsy is required, the Coroner facilitates collection of evidence and information which will assist the pathologist in the post-mortem examination including the information needed for the Child Death Protocol. All this information is sent to the pathologist. Following the autopsy, the caregivers are given some preliminary information about the cause of death (the only exception is in suspected cases of homicide).

Coroners plan their investigations by identifying issues which fall under their mandate and identifying people or records which may have needed information. At this point in the investigation, the Coroner and Regional Coroner may call the Child Death Review Unit or the Medical Review Unit for assistance. The Child Death Review Unit may provide assistance with planning the investigation and identifying issue for investigation. The Medical Review Unit may provide assistance with planning the investigation, reviewing medical records, interviewing witnesses, or taking the case through transfer of jurisdiction under Section 24 of the *Coroners Act*.

Once this planning is complete, the Coroner executes the investigation plan. The time frame for completion varies dependent on many factors: workload, complexity of the case and degree of police involvement. If the case is found to involve foul play, the Coroner plays a supportive role in the investigation of the death until the criminal investigation is complete or until a decision is made as to whether charges will be laid. This can take a lot of time, sometimes years. During this time frame, the Coroner proceeds with aspects of the investigation which do not jeopardize the criminal investigation such as examination of medical and MCFD records, and interviews with individuals who are not accused of a crime or who are not key witnesses to the events under investigation by the police. The average time frame for completion of a child death investigation involving complex medical issues takes from six months to one year. The death of a child involved in a motor vehicle accident or suicide can take from a few months to one year.

The third step is closure of the case via Judgment of Inquiry, Inquest or multidisciplinary review

When all the information needed to address the Coroner's investigation has been collected, the Coroner (in consultation with the Regional Coroner) decides the means by which this case will be closed. In some cases all the information may not be collected due to the lack of availability of this information (no witnesses or documents) or because witnesses have been uncooperative in providing this information. The decision involving the process for closure includes a review of need for recommendations and identification of the best process by which relevant, practical recommendations can be generated to serve the Coroner's prevention mandate.

In many cases there is no requirement for recommendations, and in others recommendations can be based on the findings of the investigation and included in the Judgment of Inquiry, and sent to headquarters and the Child Death Review Unit. In cases where recommendations are necessary to address a problem, the Coroner and the Regional Coroner review the case. If the death has involved a child in care, mental health and abuse issues, complex medical issues or if witnesses have been uncooperative, the case would most likely be recommended to the Deputy Chief Coroner for the Inquest process or review by

the multidisciplinary team. After the process is chosen, the case is then closed and the file is sent to headquarters and to the Child Death Review Unit. The file is usually concluded by a Judgment of Inquiry which documents the facts determined through a multidisciplinary review, along with any recommendations generated. In the case of an Inquest, the case is concluded by a Verdict at Inquest with a number of recommendations.

Throughout this process, the Coroner keeps in contact with the child's caregivers to ensure they are kept up to date as to the progress of the investigation and its outcome. The parent may request standing at an Inquest but may not participate in the multidisciplinary review process, which is part of the investigation and is conducted by the Coroner or Chief Coroner to identify recommendations to prevent future similar deaths.

Although the Coroners Service has always been responsible for investigating unexpected, suspicious and accidental deaths of children as described above, enhanced responsibilities for child death reviews were transferred to the Coroners Service from the Children's Commission as of September 30, 2002.

The Coroners Service began performing these functions in May, 2003. The lag was due to issues of budget, staffing and planning. Child death reviews for the Coroners Service only occur after the completed investigation by Coroners as part of their on-going role and responsibility for investigating unexpected, suspicious and accidental deaths in British Columbia as discussed earlier.

The main focus of the Child Death Review team is as follows:

- Quality assurance reviews of child death investigations and completed child death protocols
- Data collection, aggregate data and trend analysis to prevent further deaths
- Assistance to Coroners with child death investigation; and
- Conduct of internal multidisciplinary reviews with Coroner's staff and access to subject experts as required to discuss trends, and identify prevention strategies from a public health perspective.

To date, two such reviews have occurred, one on motor vehicle accident deaths in 2003 and another on Sudden Infant Deaths in 2004.

The Child and Youth Officer

In 2002, the Child and Youth Office (CYO) was established as a result of the core services review by government in 2001. The CYO is a statutory office appointed for a fixed term by the Lieutenant Governor-in-Council, and has the authority to make special reports to the public, and authority to comment publicly on matters affecting children and youth.

The CYO under the *Office for Children and Youth Act*: Section 3 (1) and Sub-sections 3 (2) (e) (g) (h) is mandated to observe and monitor quality of service, provide advice to government and communities, and comment publicly. The CYO can also gather information and observations on the state of services, and progress towards goals by analyzing information available within and outside of government. Through this process the CYO can inform government, communities and the public about the effectiveness, responsiveness and relevance of services for children, youth, and families.

The CYO began to develop a child death review process in the fall of 2005. The CYO Child Fatality Team has outlined a proposed role in child death reviews as follows:

- Reviewing the timeliness of the completion of the internal reviews completed by MCFD,
- Public disclosures,
- Formulating advice on systemic issues,
- Investigating child fatalities that were not subject to the Ministry's internal Director's or Deputy Director's reviews; and
- Reviewing critical injuries documented by the Ministry.

The CYO child death investigation team proposed to look at child deaths as a continuous learning process. The OCY believes that the Ministry should ensure that findings from death and injury reviews lead to improved service delivery, and that patterns and trends identified from reviews and other sources lead to reforms in provincial practice standards, qualifications, training, and service design. The focus of the CYO child death review process is to support both the Ministry's internal death review process and the external Coroners Service review process. Currently the CYO is still defining the of development of its child death review procedures.

The Ministry: 2003 to the Present

Following the Core Review, the Ministry continued its internal death and critical injury review process at the regional level for children in care, or who have become known to the Ministry in the previous twelve months.

The trend of child and youth death has changed during the past decade. There are now fewer deaths of children in care than ten or twenty years ago, and they occur for different causes from those in the general child population. The children and youth whom the Ministry serves are some of the most vulnerable and high risk children in the province. Many are born with multiple handicaps, some have suffered maltreatment and neglect, and all are at greater risk for poor health and social outcomes. Most children in care who die were born with

congenital anomalies and have complex medical needs, or die from serious illnesses such as cancer. The second leading cause of death is accidental.

Under the *Child, Family and Community Service Act*, the Director holds responsibility for deciding whether to conduct a further review of a serious occurrence such as a death or critical injury. Now that there are five regional Directors and one Director for community living, responsibility for making these decisions rests primarily with the regional Director where the incident occurred. The provincial Director is advised whether a further review is needed, and tracking of this review is carried out both in the region and the provincial Director's office.

When a child dies who had been served in two or more regions, or by an aboriginal agency, the provincial Director has a greater role in making the decision whether to conduct a review, and who should conduct it. As each region has staff in its Director's office to manage regional delegation, case consultation and the reporting of child critical injuries and deaths, there are also practice analysts who can conduct reviews. The regional Director can also access the provincial contract budget to hire a consultant to conduct a review.

However, there is currently no internal provincial oversight role for quality assurance in relation to the reviews conducted by regions between the provincial Director and the regional Directors, or the community living Director. There are also no remaining headquarters staff to support a regional review program. Nor has the provincial Director authority, legislatively or through policy, in relation to the regional Directors. This relationship is governed more by an understanding that the provincial Director, who is also the Assistant Deputy Minister, has the greater authority to make the final decision when required. However, provincial staff have maintained responsibility for training of regional staff in assuming these new responsibilities of Director, Deputy Director and practice analyst.

The relationship between the provincial and the regional Directors is guided by letters of designation issued to each director and letters of expectation from the Deputy Minister to the provincial Director. The review function has always been associated with the provision of services and case management under the child and family welfare legislation, policies and standards. The legislation and mandate is clearly tied to the role of the Director (formerly the Superintendent under the *Family and Child Services Act*). The Director is designated by the Minister of the day and in turn delegates her or his authority to social workers to carry out the mandate and functions of the act.

Aboriginal Agencies

The delegated Aboriginal Agencies continue to operate under the Provincial Director's purview. Quality assurance is managed by staff members in the Aboriginal Services Branch, who provide developmental support, clinical consultation and quality assurance support to the Aboriginal Agencies as each one develops. Reviewing, tracking, and responding to deaths, critical injuries, and serious incidents are handled centrally by staff in the Aboriginal Services Branch on behalf of the agencies.

When a review needs to occur it is conducted by staff in this branch, or by a consultant, depending on whether it is a Deputy Director's or Director's Case Review. The ongoing management and tracking of the review is done by the Deputy Director in this branch. There are now twenty three designated Aboriginal Agencies, seven of which have full delegation. Four staff members in the branch have responsibility for a cluster of agencies to provide consultation services, analytical services and support for agency development, once the enabling agreements have been signed.

Other Program Areas within the Ministry

Children and youth sometimes receive service from more than one of the Ministry's program areas: child protection and family support, children and youth with special needs, adoption, mental health, and youth justice. When a child dies who has received service from other programs, those programs also require reports on deaths and critical injuries which can necessitate a formal review.

Each program area has guidance and direction through policy or standards for staff to review and report on deaths and critical injuries of children and youth receiving services through these programs. These incidents are reviewed by provincial staff and decisions are made as to whether a more formal review is required. Further, each program area is currently authorized to conduct its own review.

When a child who has received service through more than one program area dies unexpectedly, a reviewer who is conducting a review for the child protection program can be provided with a program specialist for that area to provide subject matter expertise and advice to the reviewer.

Critical Injuries

In recent years some observers have come to believe that critical injuries of children could be a surer guide to needed improvements in case practice than the much less frequent deaths of children in care. Of course, all kinds of injuries occur during childhood and adolescent years. Many of these injuries are treated and quickly forgotten. However, for children and youth served by a child welfare agency, maltreatment does not fall into that category. Although the population of at risk children and youth may suffer normal hurts and accidents, they often have

suffered intentional injuries that leave lasting psychological and physical scars. It is important for the child serving system to know about, understand, and manage these events to improve the health outcomes for its young clients.

Within the Ministry, critical injuries were managed under the Reportable Circumstances policy and are now managed under a relevant Quality Assurance Standard. Critical injuries are divided into two categories – intentional and non intentional. The ministry intervenes in these events in one of two ways, through the child protection reporting, assessment and investigation process or through the Director's guardianship and clinical role to respond and arrange for treatment of the child and then to work with caregivers and other involved professionals for follow-up and any ongoing intervention that may be required.

Other Agencies Involved with Critical Injuries

There are specialized clinics in the province located in five regional hospitals across the province. The first such clinic Suspected Child Abuse and Neglect (SCAN) is located at the BC Women and Children's Health Centre in Vancouver. This clinic provides specialized diagnostic and treatment services to children who have been physically, sexually abused and/or neglected. Each year the clinic sees and treats hundreds of children. These children represent some of the most critically injured children in the province. In addition to children seen from the greater Vancouver area there are also children admitted from other SCAN clinics in the province to receive this specialized diagnostic service.

Some of these children have not had prior involvement or contact with the child serving system, some of these children have. Whenever a child is followed by the doctors and social workers at the SCAN clinic, a referral to the ministry usually occurs to assist and support the treatment plan. In the case of a critically injured child, the child is often admitted to ministry care. The SCAN clinic has recently updated its database to better track and report on these children. This information will become useful in providing more medical and social surveillance of abuse and neglect.

Several other agencies have developed surveillance methods for injury and death prevention that have been applied to healthcare and workplace fields such as the Public Health Agency of Canada; Worksafe BC; the BC Injury Research and Prevention Unit. There are also several arms of the Ministry of Health involved including the Provincial Health Officer and the Prevention and Wellness Planning Division- Injury Prevention. .

British Columbia Injury Research and Prevention Unit

This multidisciplinary, interagency unit was established in partnership with the Ministry of Health in August, 1997 as part of a province-wide partnership between Centre for Community Child Health Research, and BC's Children's Hospital. The BCIPRU plays a key role in coordinating unintentional and intentional injury intervention efforts through environmental modification, legislation and policy recommendations. Its goals include:

- Establishing ongoing injury surveillance across BC.
- Facilitating collaboration on provincial injury initiatives.
- Conducting and disseminating relevant and time multidisciplinary, evidence-based injury research.

Their goals are achieved through four activities:

- Population-based surveillance through Health Authorities, physicians, hospital, and public health staff to expand surveillance beyond hospitalization and mortality data.

- Community-based research involving health care providers and consumers. BCIRPU acts as a core hub for applied research aimed at developing effective community-based injury prevention strategies.

- BCIRPU provides education support and resources, encourages networking and information sharing across the province. BCIRPU also provides advanced education and training for future leaders in injury prevention.

- Dissemination of injury prevention strategy and knowledge is the key to encouraging the development of injury prevention initiatives and further research.

Since 2001, the Unit has been active on a number of fronts. It has

- assessed and rated 54 injury prevention instruments,
- developed nine injury prevention facts sheets,
- researched and developed reports on
    - Motor vehicle crashes among young drivers (2005)
    - Unintentional injuries among BC children and youth (2005)
    - Child and youth injury data from 2001-2003 (2004)
    - Economic burden of unintentional injury in BC (2001)
    - Effect of Neighbourhood, Family and Child Behavior on Child Injury (2001)

Unit research is based on trend analysis, research, best practices in other jurisdictions and partnerships with other agencies conducting multidisciplinary studies and reviews to develop recommendations for policies and programs to prevent critical injuries and premature death.

Ministry of Health Injury Prevention Unit

This unit is responsible for developing, implementing and monitoring provincial injury prevention initiatives, including those focusing on preventing premature death.

In 2004 the Ministry of Health included injury prevention as one of its strategic priorities. The strategy outlines the government's "expectations for core public health prevention and protection activities, including standards for their delivery." [20]

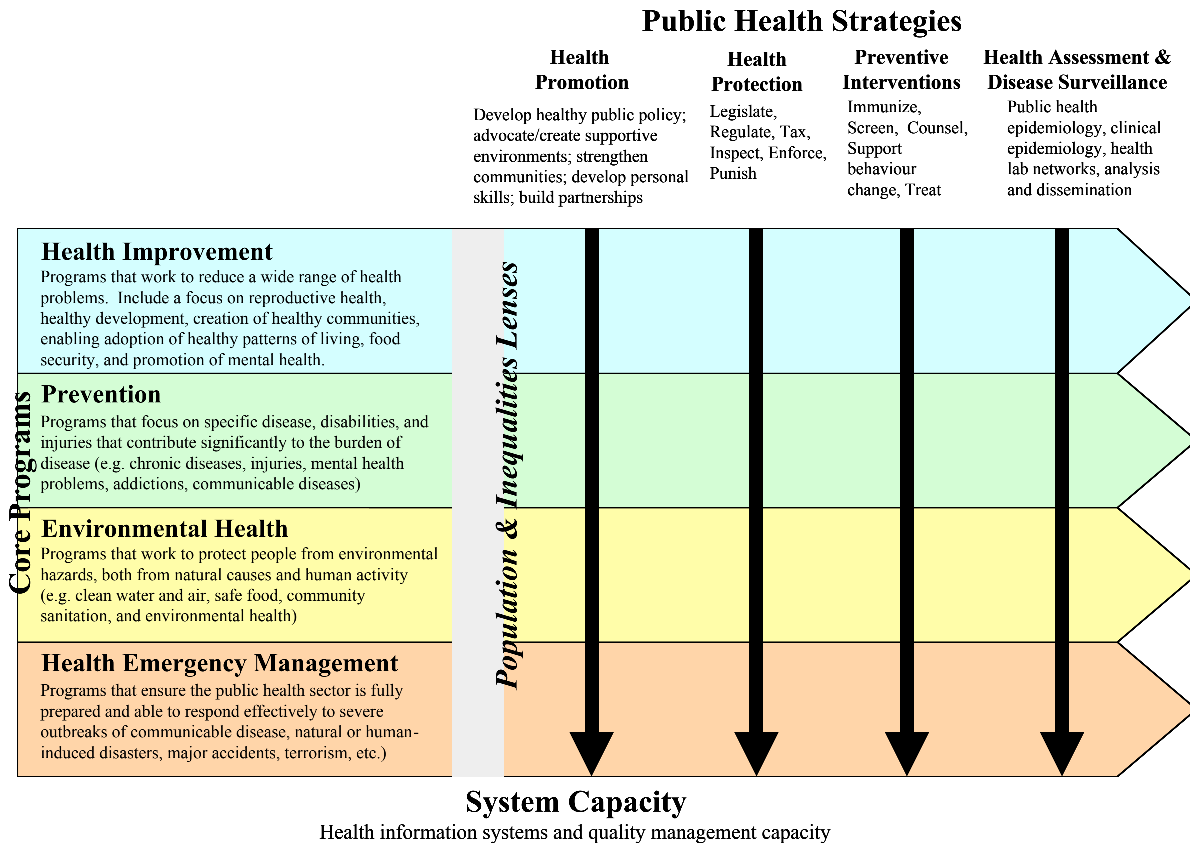


Table 2 Public Health Renewal (note Injury Prevention and prevention included as core function)

Using this health renewal matrix, information from child death reviews can form part of a strategy to prevent premature deaths, and be incorporated into the diseases surveillance and injury prevention component of the public health renewal strategy announced in 2005. A similar model (the Haddon Matrix) is used by the Coroners Service. The Haddon Matrix has been applied to

[20] BC Ministry of Health Services. (2005).

preventing motor vehicle accidents (Runyun, 1998), reducing injuries in day care facilities (Colbert, 2005), and reviewing the effectiveness of traffic accident Using this health renewal matrix, information from child death reviews can form part of a strategy to prevent premature deaths, and be incorporated into the diseases surveillance and injury prevention component of the public health renewal strategy announced in 2005. A similar model (the Haddon Matrix) is used by the Coroners Service. The Haddon Matrix has been applied to preventing motor vehicle accidents (Runyun, 1998), reducing injuries in day care facilities (Colbert, 2005), and reviewing the effectiveness of traffic accident prevention strategies in Scotland (Directorate of Information and Clinical Effectiveness 2002).

The Injury Prevention Unit in coordination with the BC Injury Research and Prevention Unit has established an Intentional Injury Network comprised of professionals from different areas in health and child welfare to begin collecting and tracking data on children and youth intentionally injured. The first surveillance project on infants recently received additional funding through the Michael Smith Foundation. The goal is to learn more about these incidents to develop improved prevention strategies. The human and social impact and cost of these injuries on the infants and their family members is a foremost reason to have better information. The more we can learn about the circumstances of these events to prevent them the better chance we have of reducing their occurrence.

Concluding Observations

In the course of preparing this background paper, a number of observations have suggested themselves. They are presented by reference to the key agencies involved.

Coroners Service

Children Involved with the Ministry and or in Care

The current system of the Coroners Service does not include specific child death review processes for children in the care of, or known to, the Ministry. Other than the internal reviews conducted by the Ministry and the proposed reviews by the Child and Youth Officer, the new approaches needed are not in place. Consideration should be given to better coordinating future Coroner investigations and recommendations with child welfare specialists from the Ministry to contribute to the prevention and public health model the Coroner is building toward.

The Model

Within the Coroners Service, the emphasis has been placed on collecting and analyzing data to determine trends to support recommendations to prevent future such deaths. This model of child death review has a different focus from the model of child death review implemented by the Children's Commission which focused more on individual and later on aggregate reviews. The current Coroner's model focuses on the latter with an emphasis on a prevention or public health model. However, to date only two such systemic reviews have occurred with limited external involvement.

Cooperation

There has been limited involvement to date with the Ministry of Health, Injury Prevention Unit, which also employs a public health model of trend analysis and multidisciplinary reviews touching related social, health and justice agencies. They focus on injury and the prevention of premature deaths. The beginning of the intentional injury surveillance network compromised of members from MCFD, Ministry of Health, SCAN of Women's and Children's' Hospital, Coroners Service and physicians from UBC is a good start. This type of cooperation should continue and be strengthened for the future.

A Children's Coroner

A new (2003) Child and Youth "specialist coroner" has added value and assistance for coroner's investigating and reviewing child deaths and has enhanced the Coroners Service ability to collect data and move towards public health trend analysis prevention model. The Child and Youth Coroner is providing expertise and support for all coroners in their investigations, developing specific investigation protocols for child death cases, and enhancing quality control of investigations.

External Resources

The Coroners Service has implemented an internal and limited multidisciplinary review of child death trends by involving subject experts as appropriate. If the new model is to create evidence-based and system-wide public health initiatives to prevent child deaths, it is not evident how the new internal model--using data and trend analysis--can succeed without use of external resources and subject matter experts.

Legislation

The Coroners Service is currently in the process of requesting changes to the *Coroners Act*. The purpose of the changes is to enact legislation similar to child death review legislation in United States. The US legislation enables CDR teams to address confidentiality, information collection and dissemination, team membership, and duties and responsibilities of the team.

In British Columbia the changes would create a child death review process supported by legislation to permit a multidisciplinary team of professionals in healthcare, injury prevention, and public health similar to the one coordinated by the Ministry of Health and the BC Injury Research Centre; to involve subject matter experts in multidisciplinary reviews looking at trends of death to develop recommendations to prevent further similar deaths; and to establish legislated requirements and time limits to report child deaths to the chief coroner.

The Coroners Service advises that legislative changes are required so that external participants in these multi-disciplinary reviews can be able to share information, and to discuss cases without having to share this information publicly. Since the announcement of the Children and Youth Review, the Coroners Service has ceased further child death review activities (other than the review of the 955 transition cases) and have put these legislative changes on hold.

Ministry of Children and Family Development

More Integrated Reviews

While the purpose of the new Ministry was to provide more integrated service delivery, the regional Directors still report difficulty in conducting one comprehensive review for a child served by more than one program area. In one recent example, a Director had to arrange for three reviews to be conducted separately due to a lack of ready coordination and information sharing between program areas.

Each division continues to manage its own clinical consultation, policy, legislation and review of incidents separately and apart from one another. The legislative mandate was not amended to account for a changed child serving system. Each program area is guided by its own legislation and policy. Nor was the quality assurance function integrated across the service sector. This was less problematic when the review function was managed centrally as additional resources and subject matter experts were easy to access for assistance as needed.

Information Sharing

Some Ministry staff believe they are constrained by information-sharing restrictions and privacy protections in the *Freedom of Information and Protection of Privacy Act* (FOIPPA). All reviews require the collection of file documents and reports. Often program areas will not share these documents with each other.

As noted above, in the future many reviews will require an integrated approach as the matter under review is at once the performance of child protection and/or

other services provided under the *Child, Family and Community Service Act* (such as support or guardianship) concurrent with services provided by mental health to the parent, or youth justice services. As the regions have more responsibility for decision making and move towards increased integration of services, the regional Director and the regional Executive Director may need a more integrated review process where all of the information from all programs is accessed without barriers to information sharing.

New Guidance

The regional Directors believe that it would assist their decision making to have new guidance and criteria in policy for deciding when to conduct a review and the scope of that review. When the review function was centralized the decision to conduct a review between 1996 and 2002 was made by the staff from a single unit. For full reviews in particular there are some common elements which provide a reason to conduct one type of review over another. Since 2003 the benefits of years of headquarters staff experience in this area have been lost.

Sharing the Lessons

Directors say that their ability to share information on “lessons learned” from reviews is hampered by a lack of coordination and the uneven dissemination of information from reviews across regions. The current recommendation tracking system is managed centrally and regional staff do not have access to it. The current database has technical limitations that preclude its transfer to the regions.

However, a new integrated tool called IPAT (integrated practice analysis tool) will be ready for implementation in June, 2006, and will have the capability to track all deaths, critical injuries, serious incidents, reviews, and audits, together with their recommendations. When this new database is operational, more provincial reports will be produced and greater analysis of case and service issues associated with the reviews should be shared among all senior and field staff,

Staffing

Regional Directors have consistently reported that they need additional staff to complete reviews and more training to conduct reviews. The need for a review curriculum has been identified as well, along with ongoing coaching and mentoring from the provincial Director’s office. Other identified needed resources include a list of more qualified consultants to conduct formal reviews.

Office for Children and Youth

Child Death and Injury Review

The Office for Children and Youth had not defined a role for itself regarding child death and critical injury review until mid 2005. The Coroners Service does not see itself in an oversight role for the child welfare system. As the Coroner moved to a public health and death prevention model, the OCY was late to begin monitoring the ministry's performance of its internal child death and injury review process and proposed improvements to its service delivery resulting from these reviews. This discovery in addition to the concern about the uncompleted child death reviews between 2002 and 2003 raised serious questions about the entire child death review system.

Experience in other jurisdictions has shown that a coordinated response to the review and investigation of child death and critical injuries can provide improvements in injury and death prevention as well as improvements to a child serving system.

The OCY has requested additional funding for 2006/07 in order to have a more robust child death and injury review function.

Cooperation

All of the public bodies involved in child injury and death review need to develop a closer and more productive working relationship. There should be regular quarterly meetings amongst all of the public bodies to promote better information sharing and planning on behalf of vulnerable children and youth. Improved cooperation could result in improved health and social outcomes for these young people.

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