REPRESENTATIVE FOR
CHILDREN AND YOUTH

Representative's Report

Nov. 7, 2007
Update #1

Critical Injuries and Deaths: Reviews and Investigations

Reporting Period: June 1 – September 30, 2007: During this period, 69 critical injuries and 26 deaths of BC children and youth who were in care or receiving reviewable services within the previous year were reported to the office of the Representative for Children and Youth (RCY). These have all received an initial review.[1]

Critical Injuries:

Upon review, it was determined that 15 critical injury cases involved only minor injuries and did not meet criteria for further review.

Of the remaining 54 critical injury cases: [2]

- 38 will be further investigated
- 13 will be sent for aggregate analysis
- decisions on 3 others are pending.

Fatalities:

Of the 26 fatalities reviewed, 17 were natural deaths of children with serious medical conditions.[3]

All of the remaining 9 fatalities will be further investigated.

General Information:

The development of baseline data needs to be strengthened for future detailed analysis, however to put the numbers in context a few comparisons can be made.

Numbers of critical injuries for this four-month period are relatively consistent with 2001 Children's Commission data. In 12 months in 2001, the Children's Commission reviewed reports of 185 critical injuries to BC children who were in care or had received reviewable services.

Numbers of fatalities for this four-month period are relatively consistent with published data from MCFD over the past several years. Many of these deaths were natural, expected deaths of children with pre-existing serious medical conditions.

The Representative for Children and Youth will do consistent and regular reporting-out in the future regarding numbers of critical injuries and deaths reviewed and investigated.

This data does not include critical injuries and deaths of children in the home of a relative (CIHR). The RCY is working with government on means to receive this data in the future.

---

[1] The reporting period begins June 1, 2007 because Part 4 of the *Representative for Children and Youth A*ct was proclaimed on that date, giving the RCY legislative power to conduct reviews and investigations.
[2] "Critical injuries" are those that are life threatening or cause serious or long-term impairment to the child's health.
[3] "Natural deaths" are classified as "expected" deaths, occurring due to a pre-existing frail condition or disease.

PURPOSE

The purpose of the RCY's reviews and investigations of child deaths or critical injuries is to identify and thoughtfully analyze recurring issues -- particularly in service delivery -- to help prevent similar deaths or injuries in the future, and to inform improvements to services. Reviewing these deaths and critical injuries is an important element of quality assurance. The review and investigation processes will be timely, fair, and thorough.

Hughes Review:
"International studies suggest it may be a mistake to torque the entire system based on the results of one or two tragic cases that occur in circumstances that might not be repeated. Critical injuries, which occur more often, may be a better indicator of needed change.
Undoubtedly, the review of individual deaths in limited circumstances is important and appropriate and can address the need to instil public confidence in the child welfare system. However, if child injury and death reviews are to achieve the objectives of improving prevention and addressing the needs of children at risk of harm, I am persuaded that the better approach is through an ongoing program of needs analysis, and evaluation of the results of interventions with children and families."

DEFINITIONS

Review:

Every case that falls under our mandate receives a thorough review of the circumstances and the services delivered to the child, as provided in the *Representative for Children and Youth Act*. This may include reviewing medical records, MCFD case files, review of relevant policies and standards, consultation with the Coroners Office and discussions with service providers, caregivers and parents.

The purpose of the review is to determine if there are service delivery issues or other circumstances that would require an investigation. Upon completion of a case review, the information is reviewed once more by the Multi-Disciplinary Team as part of an aggregate data set. Recommendations regarding service delivery may be made to the Representative by the Multi-Disciplinary Team.

Investigation:

We initiate an investigation when the circumstances of the injury or death are suspicious, self inflicted, or when there is a question as to whether neglect, abuse or services the child received may have played a role in events leading to the injury or death.

By law, RCY reviews and investigations must not inhibit the work of others. RCY investigations do not proceed until any police investigation or criminal court proceedings are completed. If there are no criminal issues, our investigations proceed when other processes, such as ministry reviews or coroner's inquests are completed, or one year after the incident, whichever is earlier. Results of investigations will be presented to the Select Standing Committee on Children and Youth, and publicly released.

Reviewable Services:

Reviewable services are services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*; mental health services for children; addiction services for children; and additional "designated services" that may be designated under a Regulation.

Multi-Disciplinary Team:

The RCY's Multi-Disciplinary Team brings together experts in the field to assist in the analysis of information gained in our reviews and investigations. Experts in public health, medicine, pathology, Aboriginal issues, policing, education, child welfare and service delivery, as well as representatives from MCFD, Community Living BC, and the Coroners Office meet to review evidence from both individual cases and from groups of similar cases.

Critical Injuries

	Total Number Reviewed	No Further Review	Decision Pending	To Aggregate Analysis	Investigation To Be Conducted [4]
Under 1 year old	1	0	0	1	0
Age 1 – 5 years	5	0	0	2	3
Age 6 – 12 years	10	5	0	0	5
Age 13 – 18 years	53	10	3	10	30
Total	69	15	3	13	38

	Child in Care [5]	Receiving Reviewable Services
Under 1 year old	0	1
Age 1 – 5 years	3	2
Age 6 – 12 years	10	0
Age 13 – 18 years	46	7
Total	59	10

Of the 38 critical injury files to be investigated, 19 were Aboriginal children or youth.

[4] The RCY Act does not allow our office to investigate until the completion of proceedings relating to the incident, such as police investigations, ministry reviews, criminal justice proceedings, coroner's inquests, etc., or one year after the incident.

[5] One reason critical injury numbers reported in "children in care" cases are higher than in "children receiving services" is because the CIC reporting system results in more consistent reporting of critical injuries. This is partially due to the fact that CICs are 'currently' known to the ministry, while children receiving services encompasses services delivered within the previous 12 months, making it more difficult to track data.

Fatalities

	Total Number Reviewed	Natural Deaths	Investigation To Be Conducted
Under 1 year old	12	6	6
Age 1 – 5 years	5	4	1
Age 6 – 12 years	6	5	1
Age 13 – 18 years	3	2	1
Total	26	17	9

	Child in Care	Receiving Reviewable Services
Under 1 year old	2	10
Age 1 – 5 years	0	5
Age 6 – 12 years	0	6
Age 13 – 18 years	1	2
Total	3	23

Of the 9 fatalities being investigated, 4 were Aboriginal children or youth.

Historic Critical Injury and Death Cases

The Select Standing Committee on Children and Youth referred four historic child death cases (deaths which occurred before June 1, 2007) and one critical injury case to the Representative for Children and Youth for review.

The RCY has monitored the recent inquests, and now will begin interviewing individuals and carrying out an extensive document and policy review.

The office of the RCY will look at the resulting data in aggregate but there will be individual case discussion. A first step in reporting out will be a report to the Select Standing Committee on Children and Youth. The reports will also be released publicly.

A date has not yet been set for reporting out however we anticipate it will be in the spring of 2008.

Deaths:

Name	Date of Birth	Date of Death	Date of Coroners Inquest
HALL, Savannah	9 Sept., 1997	26 Jan, 2001	Oct. 22 – 26/Oct. 29 - Nov. 2, 2007, Prince George
JOHN, Serena Leona Marie (AKA Wiebe),	22 Nov., 2004	17 June, 2005	October 10 - 12, 2007, Fort St. James
SIMPSON, Amanda Jean	16 Dec, 1994	2 Nov., 1999	June 11 - 15, 2007, Prince George
VON NIEDERHAUSERN, Rowen	4 June, 2001	16 Aug, 2002	June 18 - 22, 2007, Terrace

The Select Standing Committee on Children and Youth also referred one critical injury case to the Representative for Children and Youth, for review.

Critical Injury:

Name	Date of Critical Injury
Baby Cody	December 21, 2006