TRANSITION OF CHILD DEATH REVIEW FUNCTION FROM THE CHILDREN'S COMMISSION TO THE CORONERS SERVICE

Wendy Taylor
BC Children and Youth Review
April 2006

TRANSITION OF CHILD DEATH REVIEW FUNCTION FROM THE CHILDREN'S COMMISSION TO THE CORONERS SERVICE

Summary

This report provides an overview of what happened to the 955 child death "transition files" when responsibility for the child death review function passed from the Children's Commission to the Coroners Service. We discuss how these transition cases are currently being reviewed, and provide summary information on the files based on an examination conducted by the Children and Youth Review office with the assistance of researchers at the University College of the Fraser Valley. The information on the 955 files examined as part of this report is limited by the information that was available in the files, or from the Children's Commission Case Information Tracking and Reporting (CITAR) database.

The Children's Commission CITAR database, the Coroners Service, the Ministry of Children and Family Development, and the Vital Statistics Agency all record and classify information on child death differently, increasing the challenge of providing a consistent profile of these files for this report. As well, all of the agencies involved in child death reviews use different data systems, information collection forms, and different definitions and classifications. Because mandates differ, there is no standardized collection, investigation and reporting of child deaths.

The Transition Files

The former Children's Commission, the British Columbia Coroners Service and the British Columbia Vital Statistics Agency all use the International Classification of Disease standard for determining the manner of death" and the "underlying cause of death" (the so-called "NASHU" categories). There are five categories set our below:

- **Natural** is any death that is not the result of an external injury,
- **Accidental** is any death resulting from an external injury that is considered unintentional,
- **Suicide** is any death due to self induced external injury,
- **Homicide** is any death due to an external injury intentionally caused by someone else other than the deceased, and
- **Undetermined** is any death for which the cause is unknown.

Natural deaths require confirmation of death by a licensed medical practitioner. All other deaths are investigated by the Coroners Service. These are deaths that are unexpected, unexplained or unattended. A Coroner's role is to answer the questions: who died and how, when, where and by what means? The focus is on the circumstances of the death itself. A Coroner's investigation normally results in a report called a Judgment of Inquiry. Sometimes the Coroners Service will hold an Inquest. This is normally done in circumstances where there is no other way to obtain necessary evidence; if the evidence is contradictory and a hearing is needed to sort out the facts; if there is a need to bring the public's attention to a prevention issue that has gone unheeded; or if a case has been the subject of public attention and a public hearing is considered the best way to satisfy the public's need to understand.

The examination of the Children's Commission data base records of child deaths and files (now in the custody of the Coroners Service) was carried out with the cooperation of the Coroners Service and the Office of Children and Youth.

Once government had announced its adoption of the core services review recommendations in February, 2002, the Children's Commission decided not to open any new child death review files for investigation. Instead, it focused on completing the many investigations that were then underway. In June, 2002 the Commission issued its last report, noting that it had publicly reported on 769 child death reviews over the course of the six years of its operation.

The last file opened by the Children's Commission was on January 19, 2002, but the Commission (and subsequently, the Office of Children and Youth) continued to record all child deaths in the database, though paper files were not opened and investigators were not assigned.

An examination of the Children's Commission database confirmed that:

- 539 files were active at the time the office closed; and
- 244 child death files were recorded by the Children's Commission (with no paper file opened) between January 19, 2002 and September 30, 2002, when the Commission closed and responsibility transferred to the Coroners Service;
- 172 child deaths were recorded by the Office of Children and Youth in the Children's Commission's database (with no paper file opened) between October 1, 2002 and March 21, 2003, when the final entry was made.

These 955 files are referred to as the "transition files".

Of the 955 deaths, 29 were identified by the Commission as being "in care". Through the course of the review of the files we learned that the Commission did

not verify the child's legal status until the review or investigation was nearly completed and that number (29) turned out to be incorrect: in fact, 22 were in care; five had received Ministry services; and two were not known to the Ministry.

The table below shows the causes of death among the 955 transition files. It also shows the causes of death among the 22 of those children who were in care at the time of their death, and the 233 who had been receiving Ministry services either at the time of death, or during the previous 12 months.

FIGURE 2: TRANSITION FILES, CLASSIFIED BY CAUSE OF DEATH

Cause of Death	Transition files	Children in care at time of death	Children who had received Ministry Services within the year
Natural	383	11	114
Accidental	311	1	44
Suicide	69	6	24
Homicide	41	0	19
Undetermined	64	4	20
Total deaths classified	**868**	**22**	**221**
Not yet classified	55		4
Insufficient information	32		8
Total	**955**	**22**	**233**

This group of 955 transition files cannot be considered a representative sample of child death. The files span a timeframe of approximately 6 _ years, a number of these deaths occurred more than eight years ago and investigations are ongoing.

Location of the Files

Of the Children's Commission's 539 active investigation files 466 were sent to off-site storage in Victoria by the Office for Children and Youth in March, 2003, and 73 were inadvertently left in the Children and Youth Office. The Coroners Service did not believe it would need access to the 539 files. It had simultaneously been receiving information on these same child deaths from the Vital Statistics Agency, police reports, medical certificates as well as the Ministry.

The 416 database records for which paper files had not been opened remained at the Office for Children and Youth as database records. However, the Coroners Service continued to have access to these records.

On December 7, 2005 the Information and Privacy Branch of the Ministry of Attorney General and Ministry of Public Safety and Solicitor General identified all of the transition files and retrieved them, to inspect and account for each one. The names of all files were accounted for, including 56 files that had been retrieved from off-site storage by the Coroners Service in September, 2005.

The 73 Children's Commission files that were inadvertently left at the Office for Children and Youth were located at that office in November, 2005, and were also accounted for by the Information and Privacy Branch and forwarded to the Coroners Service.

Just before the Commission closed its doors, the parents and caregivers of 79 children and youth whose deaths were being investigated, had notified the Commission that they wanted to receive a copy of the completed report. The Commission had written to these parents to tell them that the Commission was closing, the investigation of their child was incomplete, and the file was being transferred to the Coroners Service. It is unclear from the information whether these parents were told that the Coroners Service would be assuming responsibility for the investigation.

In January, 2006 the Coroners Service wrote to the parents and caregivers of those 79 children and told them that the Judgement of Inquiry (Coroner's report) on their child's death was complete and if they wished a copy, they were to contact the Coroners Service. To date, eight families have asked for a copy of the Judgement of Inquiry. Twenty letters have been returned with no forwarding address. The Coroners Service will continue to try and locate these families.

In eight of the transition files, the Commission investigation reports actually had been completed. These reports are in the possession of the Officer for Children and Youth who, pursuant to the *Office of Children and Youth Act,* should determine whether and how they might be released.

In total, the 955 transition files have been located, examined and are now with the Coroners Service in Burnaby.

Examination of the Child Death Review Records
As earlier indicated, the 955 transition files were all examined, with appropriate security and confidentiality arrangements in place.

To conduct this examination and summary of the 955 transition cases, the following sources of information were used:

- All information available from the closed Children Commission files.
- Children's Commission Case Information Tracking and Reporting system (CITAR) database which tracked the child fatality cases. Examples of the type of information CITAR tracked includes: death type, the location of the death, when it happened, relationship with MCFD, and his or her surviving family members, gender, age, legal status, and the region in which the child lived.
- Completed Coroner investigations on each child's death which is recorded on the Judgment of Inquiry completed at the conclusion of the investigation into each child's death.

- Child Fatality Data Collection forms used during Coroner investigations. Coroners now complete a protocol on all child and youth deaths that provides specific information to assist with investigations and to assist with aggregate and trend analysis to prevent future similar deaths.

Not every record examined contained full information. Rather, there was a good deal of variation on how information was entered, recorded, or not recorded, in the file. For example, the birth date of a child might be unrecorded, or be recorded with a different date. As the files were at various stages of review, some contained more information than others. Nevertheless, all information available with respect to these 955 files was examined. The resulting analysis of this information provides some understanding of the demographics relating to these children and their deaths.

Demographics of the Child and Youth Death Records

Gender/Age

Of the 955 transition files reviewed, slightly more than half were boys and the average age at time of death was 8.5 years old. The most common age ranges at time of death were children who were less than a year old (32%), followed by youth between the ages of 16-18 (30%). Aboriginal children represented (12%) of these deaths.

Information on the legal status of the children--who had been the child's legal guardian at the time of death--was missing from the file or database record for almost half of the population (420 of 955 files). Among the 535 files with legal status information, 85% of the children had been living with at least one biological or adoptive parent at the time of death. This proportion was lower among the Aboriginal children in the population.

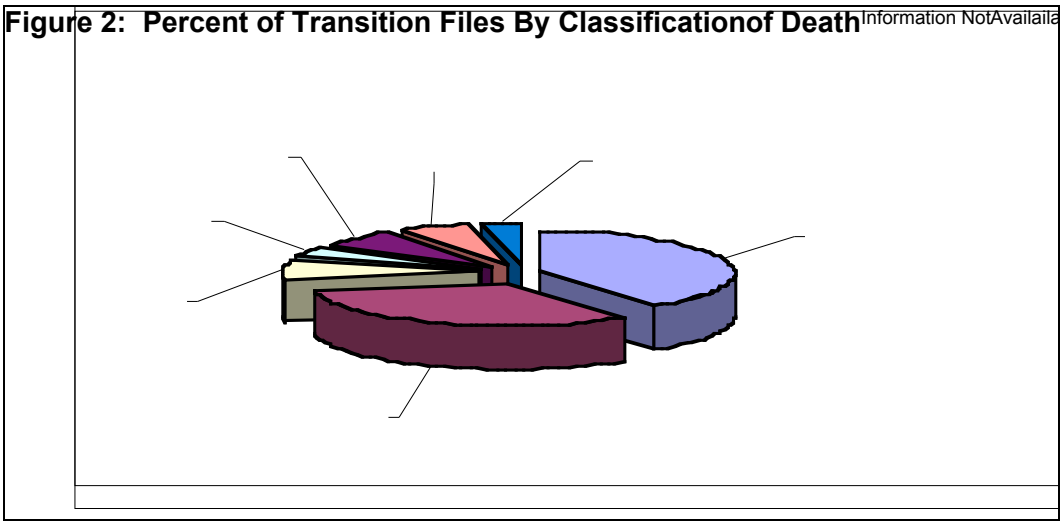
Region

The largest proportion of child deaths occurred in the Fraser region (30%), followed by the Vancouver Coastal region (18%), Interior region (18%), Vancouver Island (18%) and the North (8%). A total of 66 files arose from unknown locations and fifteen were from out of province. For Aboriginal children, the most common region was Vancouver Island (31), followed by the Interior (25), Fraser (18), and Vancouver Coastal (17) and the North (17).

Type of Death

Figure 2 outlines the breakdown of death type by NASHU death classification as found during the review of the 955 child deaths. Information on how the death occurred was not available or in the file for 3% of these cases, and death classification was pending for 6% awaiting the conclusion of the Coroner's investigation into the child's death.

Figure 2: Percent of Transition Files By Classificationof Death



Of the 955 child deaths, 383 (40%) were classified as natural, 311 (33%) were classified as accidental, 69 (7%) were classified as suicide, 41 (4%) were classified as homicide, and 64 (7%) were classified as undetermined. A further 55 (6%) were documented as “pending” classification, and the final 32 (3%) did not have enough information available in the file to classify the death.

Of the 311 children who died as a result of an accident, 40% were related to motor vehicle accidents.

69 deaths of the cases reviewed were classified as suicide with the highest number (28) caused by hanging.

Children in Care of the Ministry of Children and Family Development

Of the 955 transition files, 22 were children who were in the care of the Ministry. Eleven of those children died of natural causes, one died from an accident, six of suicide and four were undetermined.

The average age at death was ten, and the largest proportions of children in Ministry care were between sixteen and eighteen years of age (9). The next largest proportion was among children thirteen to fifteen years old (5), and one to three years old (5).

After reviewing the status of these 29 in the Ministry of Children and Family Development database, five were identified as not being in care of the Ministry at the time of death, and two were not known to the Ministry. This resulted in a total of 22 children in care. The reviewers had recorded the in-care status from the file information available. This would confirm that not all of the information in the files was correct for these investigations. It is also important to note that whether or not there was Ministry contact or in-care status was only recorded in 697 of the 955 files.

Services Accessed through the Ministry of Children and Family Development

In three-quarters of the cases examined information on whether a child had used any type of Ministry service was recorded. Among this population, 229 of the children's files indicated that a child had used Ministry services. However, specific information regarding the type of Ministry services accessed was only found in 179 of the files. While the remaining fifty files indicated that the child had accessed Ministry services, file reviewers did not find any evidence of such services in the file.

Of the one-quarter of the files in which information was found regarding the use of Ministry services, the most common service used by families was "a social worker" used by eighty-two families, although the exact kind of service provided by a social worker was not evident from the file. In addition, thirty-five families accessed counselling services, while thirty-two used home-based services. Nineteen families accessed an alcohol, drug, and/or mental health service and nineteen families used some form of at home respite.

Of the 119 files which included specific information regarding which Ministry services were accessed, twenty-eight involved Aboriginal children. The majority of Aboriginal children accessed services through a social worker (eighteen). Other services used by Aboriginals include aboriginal-specific services such as a Band social worker (eleven), and counselling (eight).

Nature of Involvement with MCFD

About a fifth of the 955 cases contained information describing the nature of a family's or child's involvement with the Ministry. The following is the breakdown of the eight main categories of their involvement as found in the cases:

- a complaint of neglect
- mental or physical impairment of the child
- parental substance abuse
- alleged physical or sexual abuse of the child
- parent cannot cope with child or needs assistance with child
- protection investigation
- illness or disease of the child and
- concern regarding the parent's ability to parent

Some forty-five of the cases reviewed involved Aboriginal children, for whom the most common reason for involvement with the Ministry was parental substance abuse (fifteen). This proportion is slightly larger than that for non-Aboriginal cases (thirteen) of parental substance abuse.

The average length of time that children who had died were involved with the Ministry was approximately five years. However, there were some cases where the Ministry was involved with a family for a substantially longer period. With

respect to the subjects, the average age at first contact was approximately five and a half years of age.

Coroners Service Investigation of the Transition Files

With its new child death review function, beginning in January, 2003, the Coroners Service began to look at all child deaths, including natural deaths. The Coroner now receives notifications from Vital Statistics on all child deaths. In the case of natural deaths, the Coroner examines the medical certificate and in about 10% of those cases, decides to investigate further.

It is important to understand the difference between the Coroner's traditional role in investigation, and the new review responsibilities that were being assumed. Under the *Coroners Act,* the Coroner investigates all unexpected, unattended and unexplained deaths, whether adult or child, to determine who died, and how when, where and by what means the death occurred.

As noted earlier, a Coroner's investigation normally results in a reported called a Judgment of Inquiry. To date, Judgments of Inquiries have been completed on 627 of the 955 child deaths.

Between 2003 and 2005, three of the 955 children's deaths have been the subject of an Inquest and a fourth is scheduled for Inquest in April, 2006. Two more Inquests will be scheduled in the near future.

In November, 2005 the Solicitor General directed that the Child Death Review Unit review all of the 955 transition files. The Coroner's Child Death Review Unit was put in place to carry out the Coroner's new child death review function. It is led by a Coroner whose focus is entirely on children and youth deaths.

The Coroners Service does not view itself as, nor was it intended to be, an oversight body for the child welfare system.

Set out below are the various steps undertaken by the Child Death Review Unit relating to the transition files.

- Medical Coroner Review of Natural Deaths – a Medical Coroner is reviewing all natural deaths among the 955 transition files to determine whether further investigation is required. Of the natural deaths reviewed so far, two natural deaths and 26 accidental deaths (coded incorrectly as natural deaths) are under further investigation.

- Coroner's Quality Assurance Review – The manager of the Child Death Review Unit undertakes a quality assurance review of all investigations

and judgments of inquiry. This review is to ensure that all investigative policies, protocols and procedures are met.

The manager reviews all recommendations arising out of a Coroner's death investigation after they have been approved by the Regional Coroner and Chief Coroner, and identifies any others that should be made to prevent future similar deaths.

The manager holds internal multidisciplinary team meetings to review trends, specific deaths and to make recommendations. The Coroners Service has not established an external multidisciplinary team due to legislative impediments. Nor is there a protocol in place between the Office for Children and Youth and the Coroners Service and the Ministry of Children and Family Development to ensure regular coordination of reviews of deaths of children who had been in care or receiving Ministry services (there is a draft protocol in progress, but on hold pending the completion of this Review).

- Coroner's Child Death Review Protocol – A comprehensive 14-page data collection form, referred to as a "child death review protocol" was developed by the Child Death Review Unit and is completed for each file investigated or reviewed. The protocol collects detailed information about the child, the child's family, and the child's connections, if any, to the ministry, as well as extensive information about the death and investigation.

- Aggregation and Analysis of Data – The Coroners Service is recording information about the 955 children's' deaths, and will aggregate and analyze the data to identify trends and patterns that will form the basis for future public reports.

In addition, the Coroners Service has done a retrospective review of all child and youth deaths since 2002, using the new child death review protocol. This information will also support future trend and pattern analysis and promote public awareness of health and safety issues.

Figure 3 below shows the status of the Coroners Service handling of the transition files as of November, 2005 and at the end of March, 2006.

At this point in time, 627 files have been reviewed, 320 are presently under review and a further 8 are under investigation.

Figure 3: Coroners Service Transition File Review

Transition Files	As of November 2005	As of March 2006
Files reviewed by the Coroner	203	627
Files under Coroner review	40	320
Files under Coroner investigation	6	8
Files pending Coroner review	706	
Total	**955**	**955**

Observations:

The following observations arise from this examination of the 955 transition files:

- It was a challenge to collect the data and record information for this report due to the different data systems, record keeping practices, and lack of consistency of record keeping and information sharing among organizations.
- All of the organizations appear to have worked very independently with different sources of information, making it very challenging to create an accurate profile and account of child death in British Columbia.
- A report should be made public upon completion of the Coroner's review of the transition files outlining the review process and recommendations made.
- In terms of child death data collection, analysis and records, consideration should be given to the following:
    - Develop consistent standards for annual reporting of mortality in British Columbia.
    - Publish and maintain data on child deaths, and explain why some of the statistics can vary from source to source.
    - Seek to develop consistent health reporting standards among other provinces.
    - Develop consistent data tracking forms and checklists for all agencies involved in the child death investigations and reviews; and
    - Agencies that conduct child death reviews should publish annual reports summarizing their reviews and enumerating their recommendations.

References

BC Children and Youth Office. (2006). CITAR Children's Commission Database.

BC Coroners Service. (1980). *Coroner's Training and Resource Notebook*. Burnaby, BC: BC Coroners Service.

BC Coroners Service. (2005). *About the Coroners Service*. Retrieved November 28, 2005 from http://www.pssg.gov.bc.ca/Coroners/service/index.htm

BC Coroners Service. (2005). *Child Death Review Overview*. Burnaby, BC: BC Coroners Service.

BC Ministry of Children and Family Development. (2006). Strategic Planning Branch.

BC Ministry of Children and Family Development. (2006). Children and Family Development Division, Divisional Operations Branch.