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Office of the Chief Coroner

Paediatric Death Review Committee and Deaths Under Five Committee Report 2015

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Message from the Chair

As death investigators, child deaths are among the most challenging cases to work on because the natural expectation and hope is for children to grow and mature to adulthood. When that doesn't happen, there is a shared sense of sadness and injustice for all involved, coupled with a desire to make things better – for families and the systems that serves them.

Our role as death investigators has two primary purposes – to answer the many questions from parents, caregivers and sometimes the criminal justice and child welfare sectors, and to help to prevent future deaths in similar circumstances.

Through shared expertise and collaboration, the Paediatric Death Review Committee (PDRC) and Deaths Under Five Committee (DU5C) help us learn from these deaths, so that this knowledge can be shared with stakeholders that are able to develop and implement changes that may help to prevent similar deaths from occurring in the future.

This year's annual report is a result of the thoughtful and thorough reviews that were undertaken by the committees. The different strengths and perspectives that make up the committees' membership enrich the analyses and support informed conclusions and recommendations. The work of the committees is greatly valued and appreciated by our organization and by the multiple other organizations that share our commitment to injury and death prevention in children.

We welcomed back Kathy Kerr as the Executive Lead for the Office of the Chief Coroner's death review committees and continued to benefit from Jessica Diamond's expertise in facilitating the child welfare portion of the PDRC and assisting with the evaluation of the paediatric death review process. Together, they brought the excellent work contributed by the committees together into this annual report. Thank you to Jessica, Kathy and all committee members for your continued excellent work.

Our report this year follows the same format and methodology as last year's, focusing on broad data analysis that includes all deaths of children that had involvement of a children's aid society within 12 months of their death. Taking this approach has provided an opportunity for us to reflect on the many unanswered questions about the deaths of children and youth and the potential of data helping us better understand and prevent them. With that said, two years of data and analysis is not enough – there is sufficient variability within the data year-over-year to merit its ongoing examination before drawing any conclusions. As time passes and the quality, reliability and scope of the data we work with continues to improve, the ability to identify trends or draw conclusions from the data will increase. I would like to thank Zak Haque, a student that worked with our office in 2015, for his contributions to this portion of the data analysis.

Last year I reported that we were embarking on a divisional strategic plan to guide our work over the next five years. Following broad staff and stakeholder consultations, the plan was completed last spring and, together with Ontario's Chief Forensic Pathologist Dr. Michael Pollanen, we introduced the implementation strategy in October. A number of initiatives stemming from the strategy are now in motion, including evaluating the approach to paediatric death review and death review committees. Our office continues to work in collaboration with the Ministry of Children and Youth Services, the Office of the Provincial Advocate for Children and Youth and other organizations internal and external to government that bring expertise in policy, health, research, evaluation and other areas to explore ways of improving the review and analysis of child deaths.

I know that many are surprised that I continue to chair these committees in addition to my position of Chief Coroner. The safety and wellbeing of children and youth is something I am passionate about, and as we embark on a number of new possibilities resulting from our evaluation of the child death review process, I remain committed to the process and to developing a new model of child death review that will support the objectives of death prevention, public safety and public education.

Dirk Huyer, MD

Chief Coroner for Ontario

Chair, Paediatric Death Review Committee and Deaths Under Five Committee

The Office of the Chief Coroner and the Context of Paediatric Deaths in Ontario

In Ontario, death investigation services are provided by the Office of the Chief Coroner (OCC) and the Ontario Forensic Pathology Service (OFPS). Together, they form a division within the Ministry of Community Safety and Correctional Services.

The OCC partners with the OFPS to ensure a coordinated and collaborative approach to conduct the highest quality death investigations in the public interest. Other key death investigation partners include police services, the Centre of Forensic Sciences and other investigative agencies including but not limited to Children's Aid Societies, the Ministry of Labour and the Office of the Fire Marshal. Ontario is the largest medico-legal death jurisdiction in North America.

In Ontario, coroners are medical doctors with specialized training in the principles of death investigation. Coroners investigate approximately 15,000 deaths per year in accordance with Section 10 of the *Coroners Act*. They investigate all non-natural deaths such as those involving violence, foul play, suicide, and where accidental injury may be involved. Investigations are completed on natural deaths that are sudden and unexpected as the manner of death is initially unclear. Other natural death investigations may occur depending on the type of death and/or if there are concerns about the care of the deceased prior to death. The Office of the Chief Coroner applies the following definitions when determining the manner of death:

Natural: a death is natural if it is due to a natural disease or complication thereof; or known complication of diagnosis or treatment of the disease.

Accident: a death is accidental if it is due to an occurrence, incident or event that happens without foresight or expectation.

Homicide: a death is classified homicide if it results from the action of a human being killing another human being.

Suicide: a death is a suicide if it results from an intentional act of a person knowing the probable consequence of what he/she is about to do - that is (the consequence would be) his/her own death.

Undetermined: a full investigation has shown no evidence for any specific classification or there is equal evidence or a significant contest among two or more manners of death.

The OCC investigates approximately 20% of all deaths that occur within the province each year. In paediatric deaths (i.e. from live birth to the nineteenth birthday), this proportion over the past five years is approximately 35%.

The Paediatric Death Review Committee (PDRC) and the Deaths Under Five Committee (DU5C) are two of the seven expert death review committees that report to the Chief Coroner for Ontario. For administrative purposes, the PDRC is composed of two sections based on the nature and circumstances of the death: PDRC - Child Welfare reviews cases with child welfare (i.e. Children's Aid Society) involvement, and; PDRC - Medical reviews the deaths of children where issues or concerns about the medical diagnosis or provision of care have been identified.

The OCC has death investigation procedures that mandate expert death committee reviews for deaths in certain circumstances. The DU5C reviews all deaths investigated by coroners involving children under the age of five. The PDRC - Child Welfare must review all deaths involving children and youth when the child the youth or their family was receiving, or had received, the services of

a Children's Aid Society (CAS) within 12 months of the death. All other reviews conducted by the PDRC, particularly those with medical implications, are done on a discretionary basis and are referred to the PDRC – Medical by the relevant Regional Supervising Coroner or DU5C.

Child and Youth Deaths in Ontario and Canada: Trends Over Time

While deaths of children and youth comprise a small percentage of those investigated by the OCC, each of these deaths is challenging from emotional and investigative perspectives. It is important to consider the findings published in the Annual Report within the broader context of childhood deaths in Canada.

While the OCC defines the paediatric age group from live birth to the nineteenth birthday, adolescent data provided by Statistics Canada also includes the nineteenth year (i.e. up to the twentieth birthday). For the purpose of the comparisons demonstrated in Charts 1 – 4, data from the OCC includes investigations of adolescent deaths up until the twentieth birthday as well. On average, the OCC investigates 63 deaths of individuals in their nineteenth year. For Charts 1 – 4, please note that 2012 is the most recent year for which complete data is available.

Chart 1 illustrates the number of child and youth deaths per year and compares the number of cases investigated by the OCC with the provincial and national numbers. Between 2005 and 2012, the year to year totals have remained fairly consistent both in Canada and Ontario, as seen in Chart 2. Chart 2 also indicates that the proportion of deaths of children and youth occurring in Ontario, as a proportion of the national total, has consistently been slightly lower than the proportion of children and youth that live in Ontario as a proportion of the national total.

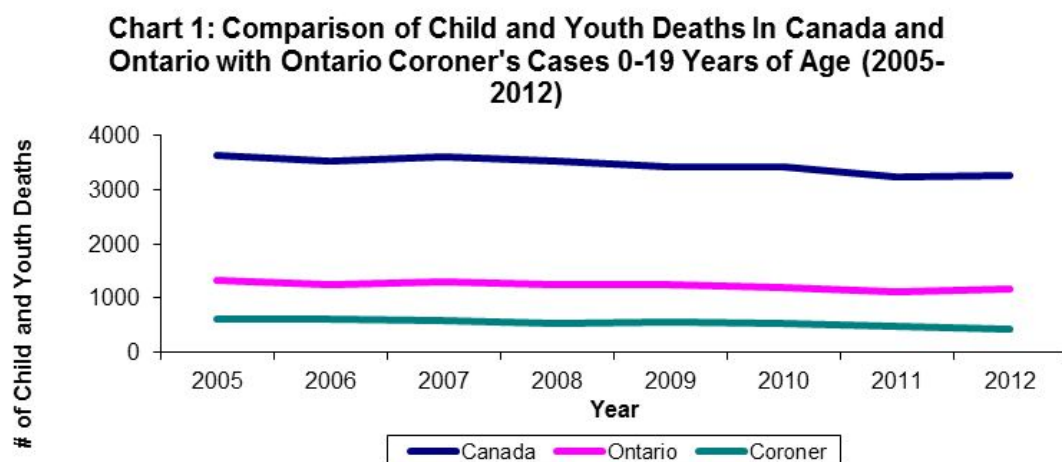


Chart 2: Paediatric population vs. paediatric deaths in Ontario compared with Canadian totals*

*Chart 2 provides the actual numbers of children and youth in Canada and in Ontario and shows the percentage of children and youth in Ontario as a proportion of the national total, and shows the number of child and youth deaths per year and the percentage of paediatric deaths in Ontario as a proportion of the national total. Between 2005 and 2012, the year to year totals have remained fairly consistent. Chart 2 also indicates that the proportion of deaths of children and

youth occurring in Ontario, as a proportion of the national total, has consistently been slightly lower than the proportion of children and youth that live in Ontario as a proportion of the national total.

Paediatric population vs. paediatric deaths in Ontario compared with Canadian totals

Year	Paediatric population – Canada (total)	Paediatric population – Ontario (total)	% of Ontario paediatric population vs. Canada	Paediatric deaths - Canada (total)	Paediatric deaths - Ontario (total)	% of Ontario paediatric deaths vs. Canada
2005	7,874,686	3,129,130	40%	3640	1335	37%
2006	7,865,435	3,127,664	40%	3513	1249	36%
2007	7,859,930	3,116,390	40%	3591	1297	36%
2008	7,869,257	3,112,369	40%	3517	1237	35%
2009	7,867,349	3,101,042	39%	3423	1247	36%
2010	7,850,628	3,087,884	39%	3424	1201	35%
2011	7,833,278	3,074,838	39%	3245	1122	35%
2012	7,828,135	3,062,498	39%	3247	1166	36%
Average	7,856,087	3,101,477	40%	3450	1232	36%

Child and Youth Deaths in Ontario: Distribution Across Age Groups

Chart 3 illustrates the average number of death investigations completed by the OCC compared with the eight year average Ontario total number of deaths, distributed by age group.

Proportionately, infants compose the largest subgroup of deaths, followed by adolescents.

**Chart 3: Average of Child and Youth Deaths in Ontario (2005-2012)
Distribution Across Age Groups**

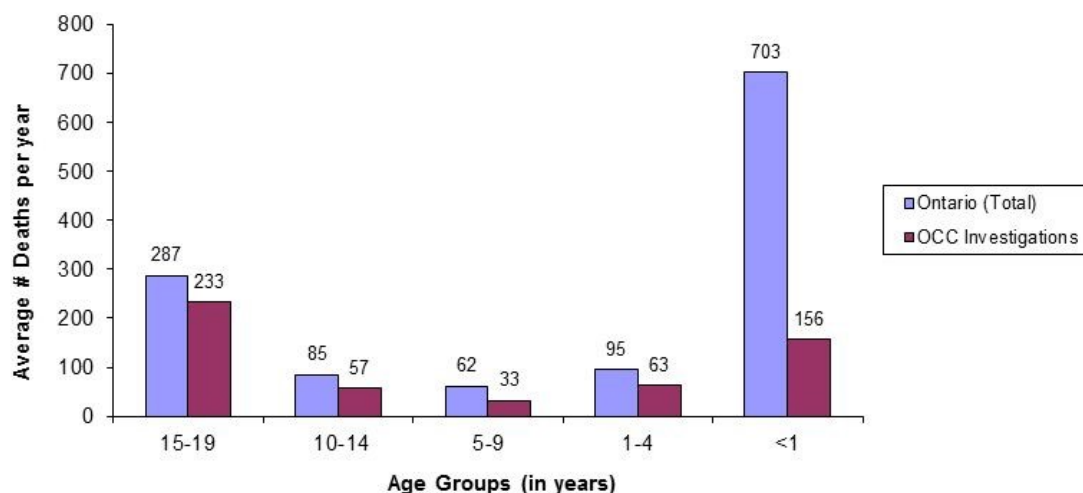
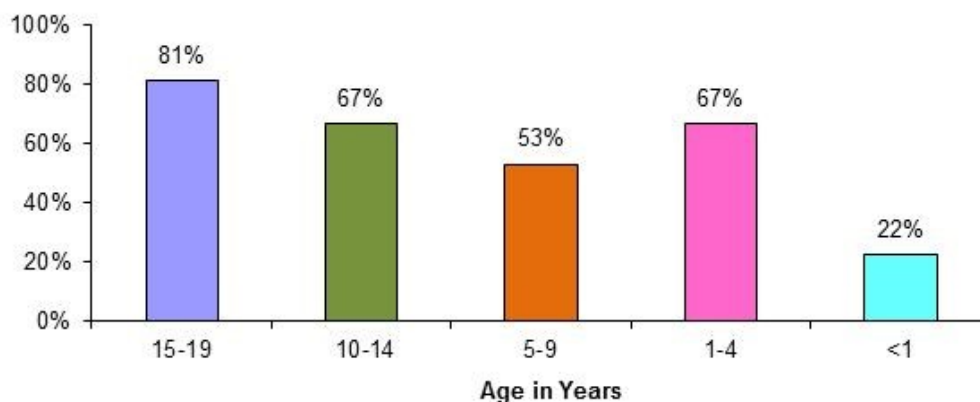
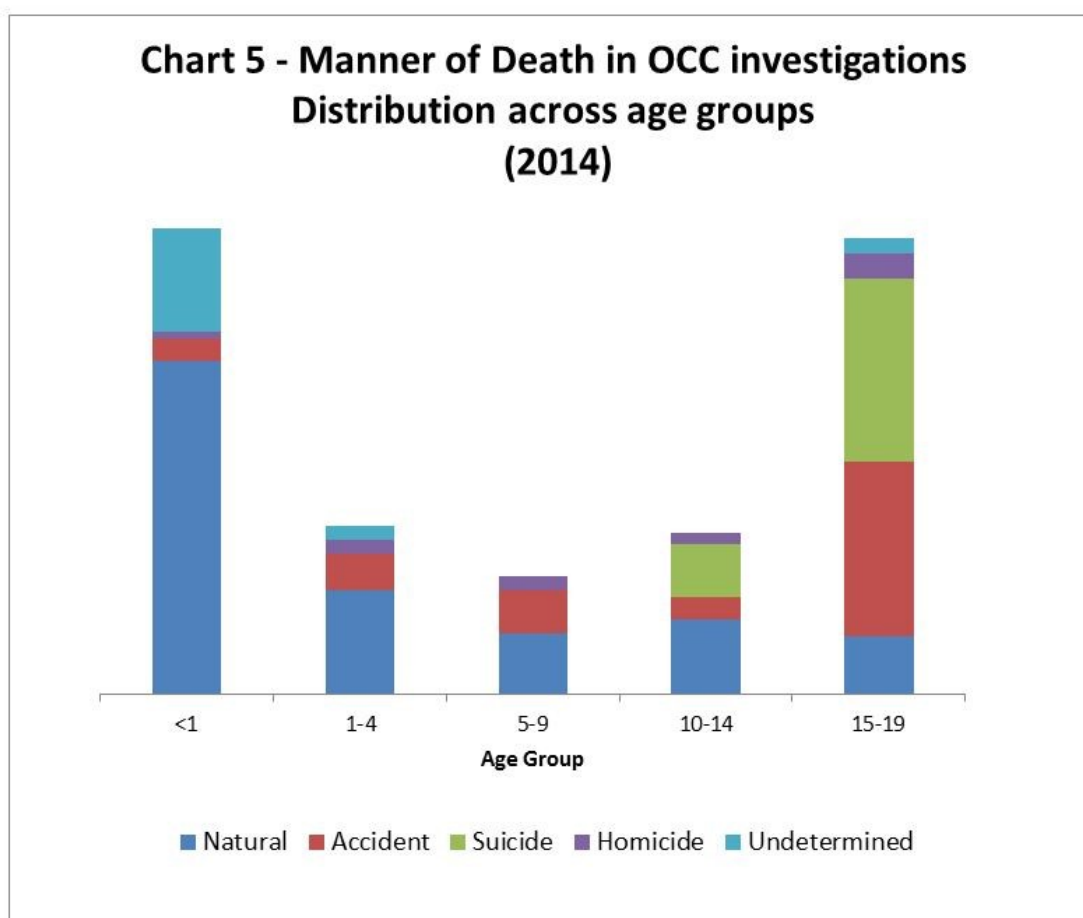


Chart 4 illustrates that over the 8-year period studied, the OCC investigated approximately 22% of infant deaths (< 1 year), 67% of deaths of 1-4 year olds, 53% of the 5-9 year olds, 67% of 10-14 year olds and 81% of adolescent deaths (15-19 year olds).

Chart 4: Average % of Cases Investigated by Coroners vs. all Ontario Deaths Based on Age Group Averages (2005-2012)



As demonstrated in Chart 5, there is a change in the distribution of the manner of death provided by Ontario coroners that follows age progression from infancy to adolescence. There is a clear contrast between the manners of death provided in infancy (< 1 year) versus adolescence (15-19 years). Natural and undetermined deaths dominate investigations of children under one, gradually changing to non-natural manners (accident, homicide and suicide) which are more prevalent among adolescents.



Deaths Under Five Committee

Introduction

The Deaths Under Five Committee (DU5C) of the Office of the Chief Coroner (OCC) meets at least six times per year for the purpose of comprehensively reviewing the deaths of children less than five years of age investigated by coroners in Ontario. It is a multi-disciplinary committee and members include forensic pathologists, coroners, police detectives, child maltreatment and child welfare experts, crown attorneys, a Health Canada product safety specialist and executive staff from the OCC. Attendance for knowledge enhancement is common, including learners from different stages of medical education and detectives from police services that are not active committee members. The membership is balanced to reflect Ontario's geography. It also includes members from ten police agencies that provide diversity in terms of geographic area, size of police service and the skill set of the investigators.

Scope and Mandate

The DU5C reviews all cases investigated by a coroner involving the deaths of children under five years of age including, neonatal cases where the death was potentially linked to parental behaviour (e.g. sleep circumstances/unsafe sleep environment, maternal substance use, neglect, domestic violence, etc.) and those in which the Children's Aid Society (CAS) was involved at time of the death. The committee does not review neonatal deaths that occur prior to discharge from hospital where no substantive issues have been identified.

The mandate of the DU5C is to determine the cause and manner of death for all cases meeting the criteria for review. Case-specific recommendations for additional investigation, further laboratory/pathologic testing, evaluative testing of relatives or systemic improvements may arise during the review.

DU5 Review Process

Cases are referred to the DU5C by the relevant Regional Supervising Coroner. Case reviews are not confined to deaths that occurred during the calendar year of the Annual Report. Given the complexities involved in paediatric death investigations, the investigations sometimes take a long time to complete, delaying the DU5C review.

The DU5C review is a two-tiered “triaging” process involving an Executive Team Review and/or Full Committee Review.

Executive Team

The Executive Team reviews cases of deaths under five that are:

- Natural deaths with defined illnesses and no issues (i.e. the deaths are “all natural” and there are no police or child welfare concerns)
- Accidental deaths that are well documented where no issues have been identified (e.g. motor vehicle collision, drowning)
- Homicides or criminally suspicious deaths where the case is still under active police investigation or before the courts.

The cases are received, tracked and triaged by the Executive Team, whose membership includes the DU5C Chair, Executive Lead and other individuals as necessary.

Full Committee

The full DU5C includes the multiple disciplines noted above. The full committee reviews cases of deaths under five including:

- All cases where the cause of death remains undetermined after a complete investigation
- Deaths where the sleep circumstances\unsafe sleep environment may have been a potential contributor
- Potential cases of Sudden Infant Death Syndrome (SIDS)
- Natural deaths with complex medical presentations where potential investigative or pathologic issues that may affect the cause and/or manner of death have been identified
- Accidental deaths involving unusual circumstances
- Deaths resulting from head injuries that are not well documented accidental deaths (i.e. motor vehicle collision)
- Homicides (when the investigation and court process has been completed)
- Most homicides are reviewed by the Executive Team and presented to the committee prior to completion of the court process given the time period until resolution in the criminal justice system

Cases referred to the DU5C undergo a comprehensive and detailed review of investigative materials including (but not limited to):

- Post Mortem Examination, toxicology results and other investigative findings
- Photographs (of the scene and Post Mortem Examination)
- Coroner’s Investigation Statement

- Investigation Questionnaire for Sudden and Unexpected Deaths in Infants
- Police and other investigative reports (e.g. Fire Marshal and CAS reports, etc.)

Chart 6 Illustrates that over the past five years, the full DU5C reviewed between 55 and 108 cases. The manner of death for the majority of cases for all five years was “undetermined.”

Chart 6: DU5C - Full Committee Reviews Based on Manner of Death 2010-2014

Year	Natural	Accident	Homicide	Undetermined	Total
2010	17	14	4	73	108
2011	3	13	3	79	98
2012	6	2	9	75	92
2013	3	3	0	49	55
2014	7	4	0	53	64

DU5C cases reviewed in 2014

Summary of Full DU5C Reviews in 2014:

- In 2014, the full DU5C reviewed 64 cases.
- 67% (43) of the cases reviewed by full DU5C involved male children and 33% (21) female children.
- 87% (55) of the cases reviewed by the full DU5C involved children less than one year old.
- Of the cases reviewed by the full DU5C involving children less than one year, the manner of death was 87% (48) undetermined, 9% (5) natural and 4% (2) accident.
- 13% (9) of the cases reviewed by the full DU5C involved children aged one to five years.
- Of the cases reviewed by the full DU5C involving children aged one to five years, the manner of death was 22% (2) natural, 22% (2) accident and 56% (5) undetermined.
- Collectively, for all full DU5C reviews, the manner of death was 83% (53) undetermined, 11% (7) natural and 6% (4) accident.
- Cases reviewed by the Full DU5C involved deaths that occurred in 2011 (2); 2012 (12), 2013 (42), and 2014 (8).

Summary of Executive Reviews in 2014:

- In 2014, the executive team reviewed 82 cases.
- 52% (43) of the cases reviewed by the executive team involved male children and 48% (39) female children.
- 45% (37) of the cases reviewed by the executive team involved children less than one year old.
- Of the executive reviews involving children less than one year, the manner of death was 89% (33) natural, 5% (2) homicide, 3% (1) undetermined and 3% (1) accident.
- 55% (45) of the cases reviewed by the executive team involved children aged one to five years.
- Of the executive reviews involving children aged one to five years, the manner of death was 49% (22) natural, 38% (17) accident, 6% (3) undetermined and 6% (3) homicide.

- Collectively, for all executive team reviews, the manner of death was 67% (55) natural, 22% (18) accident, 6% (5) homicides and 5% (4) undetermined.
- Cases reviewed by the executive team involved deaths that occurred in 2012 (11), 2013 (46) and 2014 (25).

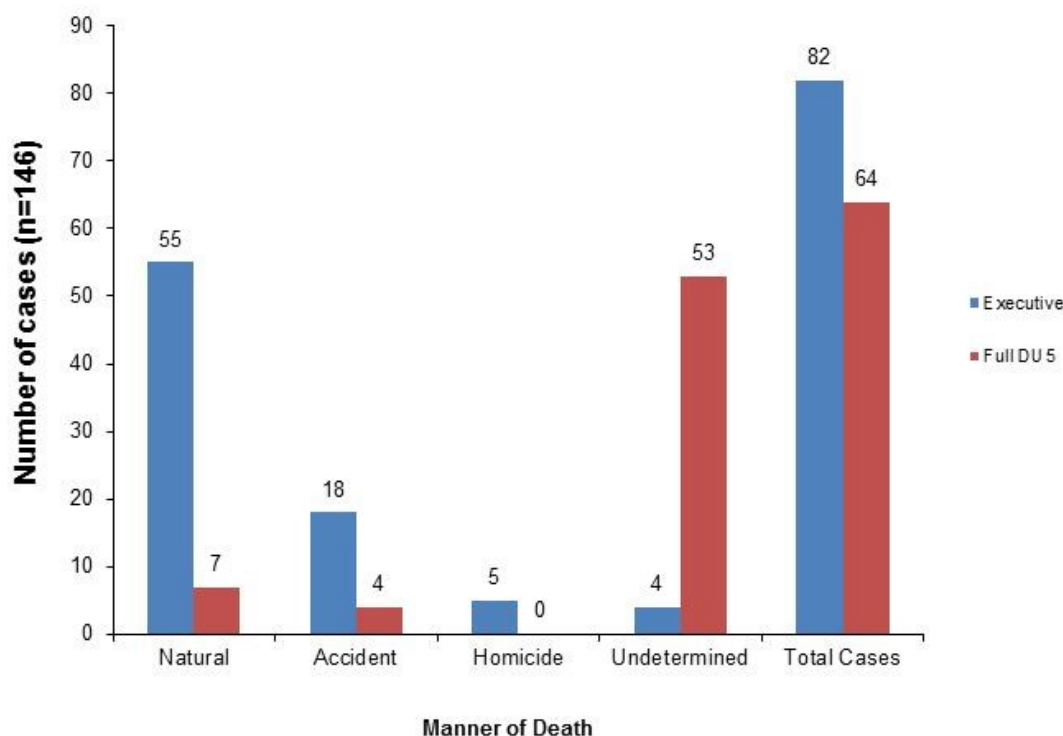
Total Cases Reviewed by the DU5C (Executive Team + Full Committee) in 2014:

- In 2014, there were 82 cases reviewed by the executive team and 64 cases reviewed by the full DU5C, for a combined total of 146 cases.
- 59% (86) of all cases reviewed by the executive team and full DU5C involved male children and 41% (60) female children.
- Collectively, for all executive team and full DU5C reviews, the manner of death was 43% (62) natural, 15% (22) accident, 3% (5) homicide and 39% (57) undetermined.
- 83% (121) of the cases reviewed by the executive team and full DU5C involved deaths that occurred in 2013 and 2014.

Analysis of findings:

- **Chart 7** demonstrates the difference in findings of manner of death between cases reviewed by the executive and full DU5C reviews.
- The majority of executive reviews involved natural deaths.

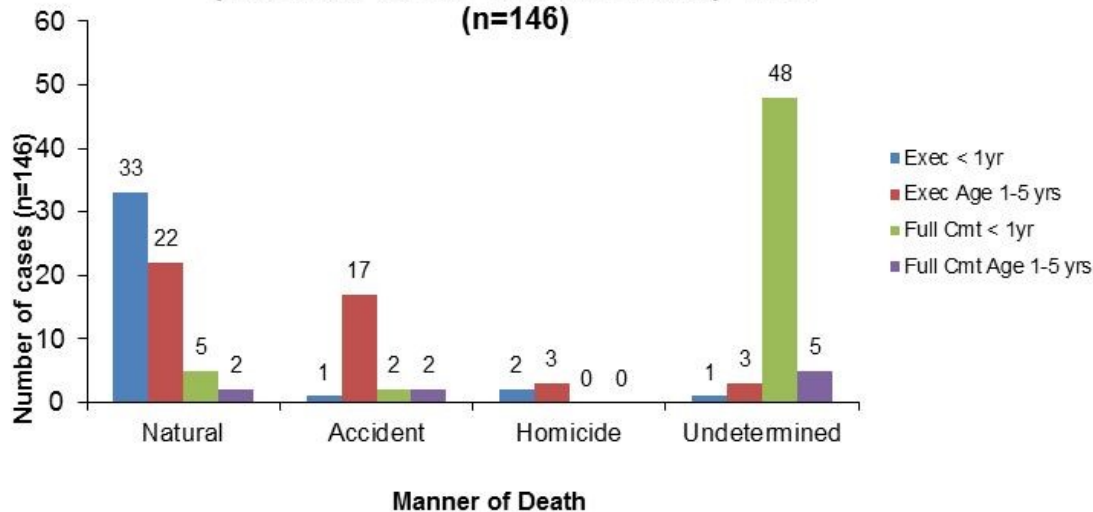
**Chart 7: Manner of Death
Executive vs. Full DU5 Review (2014)
(n=146)**



- **Chart 8** demonstrates the manner of death categorized by age for both the executive and full DU5C

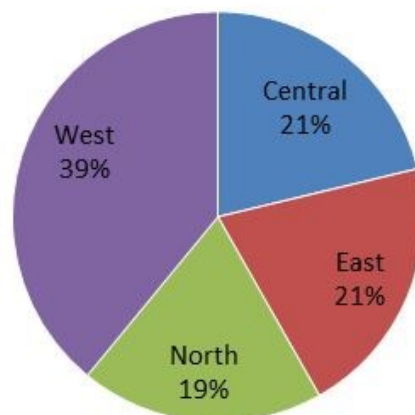
- The majority of executive reviews of natural deaths involved children less than one year old.
- The majority of full DU5C reviews of undetermined deaths involved children less than one year old.

Chart 8: Manner of Death based on age (< 1yr vs. 1-5 yrs) and level of review (Executive vs. Full DU5 Committee) - 2014 (n=146)



- **Chart 9** demonstrates that 39% of all DU5C referrals in 2014 came from West Region and 21% of referrals came from both Central and East Region.

Chart 9: % of Total DU5 Reviews based on Region (2014) (n=146)



Determining the Cause and Manner of Death

One of the greatest challenges the DU5C reviewers face is trying to properly assign manner and cause of death. The most challenging cases are in children less than one year of age, where the autopsy has not clearly demonstrated a cause of death. Even with the most qualified and experienced forensic pathologists performing the autopsy, it is not uncommon for the cause of death to be undetermined.

Learning more about sudden and unexpected infant deaths and advancing our findings is a priority for Ontario's death investigation system with regular discussion about the approach to death investigation, and specifically, post mortem examination at the time of a sudden and unexpected infant death.

The Ontario Forensic Pathology Service (OFPS) adhere to scientifically informed guidelines that forensic pathologists follow when they complete these examinations at regional forensic pathology units. Ancillary testing includes: extensive histology; microbiologic evaluation; toxicologic analysis and detailed metabolic analysis. Additional testing and expert evaluation are completed when required and DNA is routinely isolated and retained.

Ontario's death investigation system works closely with paediatric cardiologists and geneticists who have expertise in evaluating heritable cardiac abnormalities. Consultation with these experts has informed the development of a protocol that allows request for molecular testing of retained DNA samples. It is believed that clinicians are in the best position, based upon their clinical assessment of family members, to determine the most appropriate testing.

In Ontario molecular testing is not completed in all cases of sudden and unexpected infant death. This is a topic of regular review and discussion within the death investigation system and with expert paediatric colleagues. While molecular testing can be considered in all sudden and unexpected infant deaths, concern remains that when testing identifies abnormalities of unknown significance relating to the death, reporting the abnormality could lead to undue concern for surviving and future family members.

It is recognized that there continues to be significant advances in the area of molecular testing and anticipate a different approach to testing in the future.

The classification of infant deaths continues to be a topic of discussion for the death investigation field. Different death investigations, including Canadian provincial and territorial jurisdictions, use their own approaches in the classification of infant deaths. Consistent use of definitions and terminology is important to ensure clear understanding and effective classification of sudden and unexpected infant deaths.

One of the significant changes reflected in the classification of these deaths (see Chart 10) involves the cause of death being provided as "undetermined" in cases where there is a comprehensive investigation but no conclusive finding. Previously, based upon a 2005 publication of the National Association of Medical Examiners, many death investigation jurisdictions use the often confusing "Sudden Unexpected/Unexplained Death in Infancy (SUDI)" on the Medical Certificate of Death. This terminology is not used by the DU5C.

Cause of Death on Death Certificate

Chart 10 - Infant Death Classification

Autopsy Findings	Investigative Findings	Cause of Death on Death Certificate	Manner of Death

1. Autopsy reveals a definitive cause of death (pneumonia, head injury, etc.) that informs a definitive manner of death	Variable/may directly inform cause/manner of death	As per the autopsy/investigative findings	Based on autopsy/circumstances
2*. No anatomic or toxicologic cause of death identified	No findings of concern identified during the complete investigation - child found supine or prone - no evidence of sleep- associated circumstances** - may include exposure to environmental tobacco smoke or in utero tobacco use	1a- Sudden Infant Death Syndrome (SIDS)	Natural
3A. No anatomic or toxicologic cause of death identified	Presence of sleep associated circumstances ** Presence or absence of social risk factors***	1a- Undetermined 1b- 2-Unsafe Sleep Environment (description in parentheses) ---OR--- 1a- Undetermined 1b- 2-	Undetermined

3B. No anatomic or toxicologic cause of death identified	Includes cases that do not meet definition of SIDS No sleep associated circumstances** May be presence of social risk factors ***	1a- Undetermined 1b- 2-Unsafe Sleep Environment (description in parentheses) ---OR--- 1a- Undetermined 1b- 2-	Undetermined
4. No anatomic or toxicologic cause of death identified	Findings in investigation/ autopsy, examples include: - autopsy findings for which the differential diagnosis includes non- accidental injury (ex: healing fracture, bruises, etc) -death of a previous child in suspicious circumstances -significant toxicologic findings for which there is an inadequate explanation	1a- Undetermined 1b- 2-	Undetermined

** Sleep associated circumstances include:

- Sharing a sleep surface with a person or pet (adult, toddler, child, cat, dog, etc.)
- Sleeping on a surface not intended for infant sleep (adult bed, waterbed, sofa, child carrier, car seat, non-approved playpen or bassinet)
- Sleeping in a cluttered sleep environment (bedding, toys, clutter in the sleep area that represent an asphyxia potential)

*** **Social Risk Factors**, including, but not limited to:

- Previous involvement with child welfare agencies, substantial mental health histories in caregivers, domestic violence in the home, alcohol or substance use in the caregivers, concerning, but non- specific investigative findings (ex: inconsistent accounts of circumstances surrounding the death)
- these risk factors will not be listed on the Medical Certificate of Death.

* **Category Two** represents deaths that meet the definition of Sudden Infant Death Syndrome (SIDS)

As defined: Sudden death of an infant under 1 year of age that remains unexplained after a thorough case investigation, which must include:

- A complete autopsy
(including full skeletal survey & toxicology)
- Review of the circumstances of death
- Examination of the death scene
- Police investigation
- Review of the clinical history

A death will not be considered in Category 2 if any of the following is/are present:

- SIDS definition is not met
- Presence of sleep associated circumstances (described above):
- Presence of social risk factors (described above)
- Anatomic or toxicologic findings that do not establish a cause of death, but for which the differential diagnosis includes maltreatment, and the caregiver has no explanation for the findings, or the caregiver's explanation for the findings is unwitnessed, or undocumented

A death would be considered as Category 4 if:

- Anatomic or toxicologic findings are present that do not establishing a cause of death, but for which the differential diagnosis includes non-accidental injury, AND the caregiver's explanation of these findings are unwitnessed or undocumented.

Deaths Under Five Committee Classification of Infant Deaths

In 2014, 63% (92 of 146) of the deaths reviewed by the DU5C occurred in infants who were less than one year of age. The categorization of infant deaths reviewed by the DU5C in 2014 is illustrated in Chart 11.

Chart 11: Classification of infant deaths (under age 1 year) reviewed by the Deaths Under Five Committee in 2014

Chart 11: Classification of infant deaths (under age 1 year) reviewed by the Deaths Under Five Committee in 2014

Autopsy findings	Investigative Findings	Environment	# of 2014 DU5 Cases (Executive + Full Committee) involving infants under age 1 year	% of total DU5C Reviews involving infants under age 1 year

Autopsy findings	Investigative Findings	Environment	# of 2014 DU5 Cases (Executive + Full Committee) involving infants under age 1 year	% of total DU5C Reviews involving infants under age 1 year
1. Autopsy reveals a definitive cause of death (e.g. pneumonia, head injury, etc.) that informs a definitive manner of death	Variable/may directly inform cause/manner of death.	Natural Accident (with unsafe sleep environment) Accident Homicide Total	37 1 2 2 42	46%
2. No Anatomic or toxicologic cause of death identified	No findings of concern identified during the complete investigation - child found supine or prone - no evidence of sleep-associated circumstances - may include exposure to environmental tobacco smoke or utero tobacco use	Natural - SIDS	1	1%
3A. No Anatomic or toxicologic cause of death identified	Presence of sleep associated circumstances and/or presence or absence of social risk factors	Undetermined (unsafe sleep circumstances) Unsafe sleeping environment Bedsharing	42 (24 cases) (18 cases)	46%

Autopsy findings	Investigative Findings	Environment	# of 2014 DU5 Cases (Executive + Full Committee) involving infants under age 1 year	% of total DU5C Reviews involving infants under age 1 year
3B. No Anatomic or toxicologic cause of death identified	Include cases that do not meet definition of SIDS. No sleep associated circumstances. May be presence of social risk factors.	Undetermined	4	4%
4. No Anatomic or toxicologic cause of death identified	Findings in investigation/autopsy, examples include: - autopsy findings for which the differential diagnosis includes non-accidental injury (e.g. healing fracture, bruises, etc.) - death of a previous child in suspicious circumstances - significant toxicologic findings for which there is inadequate explanation	Undetermined - no explanation	3	3%
			Total	92

The Importance of Consistent Definitions

Clear understanding and effective classification of sudden and unexpected infant deaths can be hampered by inconsistent use of definitions and terminology. There is variable use of terminology in scientific and medical literature when discussing unexpected infant deaths. Death investigation organizations frequently have individualized approaches to the classification of these deaths.

To accurately study unexpected infant deaths, data needs to be collected from consistently defined records and reports. Collection of consistently defined data sets across many death investigation systems would enable a true analysis of the key factors contributing to these deaths – if the definitions are not the same, it is difficult to compare. The more data we can gather from these tragic deaths, the better positioned our community safety partners will be to develop strategies to prevent similar deaths.

Sudden Infant Death Syndrome (SIDS)

The Ontario death investigation system continues to use the term Sudden Infant Death Syndrome (SIDS) as a classification of a unique category of natural infant deaths, where in the future, a specific underlying natural cause may be found, e.g. cardiac, neurologic, metabolic. These are cases that would benefit from further research within the scientific community that may find common underlying factors causing these deaths. The value of categorizing deaths as SIDS (i.e. recognizing SIDS as an “entity”) has been clearly demonstrated through focused research projects. The **Back to Sleep Program**, for example, had significant public health benefit, contributing to a 53% reduction in deaths. Research in this area is ongoing by several others.

In Ontario, SIDS is provided as a cause of death following a thorough review of all components of the death investigation including: the autopsy; examination of the death scene; review of the clinical history; and a review of the police investigation. The death is then reviewed by the DU5C, who will only attribute the death to SIDS if a consensus decision is reached that the case strictly meets the definition. The DU5C strictly applies the definition of SIDS and excludes cases with even minor deviations. SIDS is only given as a cause of death when all other causes have been ruled out. If the investigation reveals any concerning finding, the cause of death will not be classified as SIDS. It is a finding of exclusion, which is why there was only one SIDS case in 2014.

Understanding the Manner of Death

The following is a discussion about the classification system to ensure those reading this report – families, health care providers, academics, researchers, prevention experts, advocates, media, and others – have insight into Ontario’s approach to help understand the data presented.

In 53% (49 out of 92- see data in Chart 11 – Sections 3A+3B+4) of infant deaths reviewed in 2014 by DU5C, the manner of death was “undetermined.” Undetermined is one of four potential manners of death that would apply in infancy.

The Office of the Chief Coroner applies the following definitions when determining the manner of death:

Natural: a death is natural if it is due to a natural disease or complication thereof; or known complication of diagnosis or treatment of the disease

Accident: a death is accidental if it is due to an occurrence, incident or event that happens without foresight or expectation.

Homicide: a death is classified homicide if it results from the action of a human being killing another human being.

Undetermined: a full investigation has shown no evidence for any specific classification or there is equal evidence or a significant contest among two or more manners of death.

The manner of death is informed by the autopsy and other investigative findings. At times, the external and internal examinations completed at the time of autopsy do not reveal an anatomic cause of death. This is more common for infant deaths than youth or adult cases.

A so-called “negative autopsy” may present in a number of situations including, but not limited to:

- Toxicologic deaths
- Metabolic disorders
- Asphyxial deaths (e.g. airway obstruction)
- Infectious disease

- Cardiac diseases (e.g. conduction disorders)
- Sudden Infant Death Syndrome (SIDS)

To evaluate for these potential causes, ancillary (additional) testing is completed. This includes: histologic review, vitreous biochemistry, toxicologic analysis, metabolic and microbiologic testing for infectious agents. These tests may identify a cause of death and a specific manner of death can be determined.

It is important to look at how all the information available fits together when investigating death. For example, information about the incident leading to the death can be helpful when considering the autopsy findings in drowning cases. Investigative information may also be of assistance in determining cause and manner of death. For example, a negative autopsy with observed sudden cardiac arrest with accompanying defibrillator data indicating definitive arrhythmia, may allow an opinion of Sudden Cardiac Death with natural manner.

Alternatively, in criminal cases, a police investigation may demonstrate clear evidence of airway obstruction while the post mortem examination did not demonstrate any pathologic findings (with cause of death provided as undetermined) leading to the manner of death being provided as homicide.

The finding of undetermined cause and manner of death is challenging for investigators and family members to receive, given the lack of conclusiveness and/or the fact that other potentials remain. This is especially true within the context of the emotional response that accompanies any death, especially infant deaths. An undetermined finding follows careful consideration of all the evidence, and is a true representation of a thorough investigation. It should not be considered a failure to reach this conclusion. The classification of undetermined allows for future review that may contribute to a better understanding and knowledge about infant deaths.

The undetermined classification is applied when the death investigation system is not able to clearly delineate the cause and manner of death. Therefore, deaths classified as undetermined may include SIDS deaths.

Unsafe Sleep Circumstances - Determining the Role

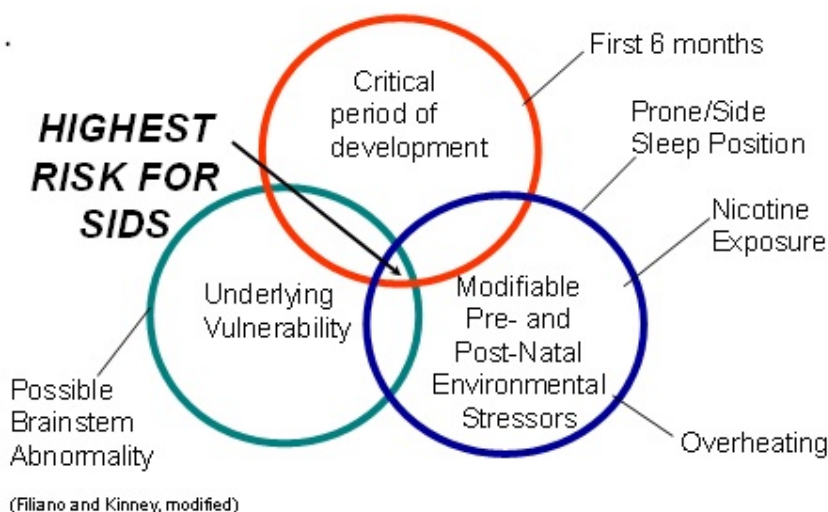
Specific findings during post mortem examinations are typically absent in situations of airway obstruction in infants, whether intentional, accidental (e.g. overlay during bed sharing) or other unsafe sleep circumstances.

Potential unsafe sleep circumstances exist along a continuum, from the defined safe environment (i.e. infant sleeping on their back in an uncluttered crib that conforms to regulation) to situations clearly identified as dangerous and likely a direct contributor to death. The lack of specific pathologic findings of airway obstruction and the potential of other unidentified causes of death have hampered the ability to accurately determine how frequently unsafe sleep circumstances cause infant deaths. These limitations require assigning an undetermined manner of death. However, experience in Ontario, supported by epidemiologic data, is that sleep circumstances may be a contributing factor in many cases.

Capturing Factors Potentially Related to the Death

A risk factor is something associated with ill health, disease and death; it may predispose individuals to develop a particular disease. SIDS has been conceptualized as a "Triple Risk Theory" where a child with (1) an underlying vulnerability (2) at a critical period of development is (3) exposed to an external factor align to lead to the death.[1]

Triple Risk Model to explain SIDS



In most literature, accepted risk factors associated with SIDS include: prone positioning, cigarette smoking during pregnancy (and in the post-delivery period) and overheating. These external factors have been defined as modifiable risk factors that predispose the infant to be directly affected by an underlying natural abnormality.

It is unclear where on the safe sleep continuum specific external factors identified in individual death investigations move from acting as factors that predispose to a natural death (e.g. SIDS) to those that directly contribute to an accidental death (e.g. airway obstruction during overlay while bed sharing or suffocation on a soft sleep surface). In other words, we don't know the dividing point on the continuum from natural to accidental death.

The DU5C considers the potential contribution of sleep related circumstances within the context of stratification of risk (based upon literature and experience). During case review by the DU5C, unsafe sleep circumstances found at the death scene preclude the death from being classified as SIDS. Any factor identified at the death scene which might interfere with an infant's breathing and/or cause entrapment, overlaying, or suffocation is identified. These include: sharing a sleep surface; unsafe sleep surfaces (not intended for infant sleep) such as adult mattresses, waterbeds, couches, car carriers, car seats; a safe sleep surface which is cluttered with toys, blankets and pillows; or a non-approved bassinet or playpen. This is in contrast to previous literature and the practices of some jurisdictions, where these deaths are classified as SIDS.

The association between unsafe sleep environments and sudden unexpected infant deaths has been recognized by death investigators and researchers for many years. The literature, including a number of recent publications, adds to the growing field of knowledge about infant deaths. Two articles of interest are: Sleep Environment Risks for Younger and Older Infants (Colvin, JD, Collier-Akers V, Schunn C, et al. Pediatrics 2014; 134: e406-e412); and the **Registered Nurses' Association of Ontario Working with Families to Promote Safe Sleep for Infants 0-12 months of age**.

Additional research and documentation of sleep environments at the time of death is necessary to help understand the cause and effect and identify potential prevention strategies. When it is believed that the sleep environment may have contributed to the death, it is included as a contributing factor on the Medical Certificate of Death. This will be captured as data which can be used to inform the development of public health policies and further research into unsafe sleep environments and the potential role in sudden and unexpected infant death. This is reflected in Category 3A in Charts 10 and 11.

While the DU5C recognizes the convention of not including contributing factors when the cause of death is undetermined, the committee believes that these cases are a special group and deserve a unique approach. The committee maintains that entering potential contributing factors on the Medical Certificate of Death is more inclusive and recognizes the scope of the death investigation. Similar to the identification of SIDS as a special group, this may allow easier identification for further case study, facilitating future research and potentially informing a public safety approach.

Unsafe Sleep Environment – What is the data?

Review of Chart 11 demonstrates that there were 49 infant deaths reviewed by the DU5C in 2014 where the manner was deemed to be undetermined (Categories 3A + 3B +4). There were 42 infant deaths classified as 3A (unsafe sleep circumstances) indicating that sleep circumstances may have been a contributing factor.

Paediatric Death Review Committee – Medical

The Paediatric Death Review Committee (PDRC) – Medical is a multi-disciplinary committee that consists of specialized paediatric practitioners including: paediatric pathology, paediatric critical care, community paediatrics, paediatric emergency medicine, neonatology and cardiology. The membership is balanced to reflect Ontario's geography and includes differing levels of institutions that provide paediatric care and teaching centres, when possible.

Medical reviews analyze and consider the medical issues involved in the time preceding a child's death to gain a better understanding of the circumstances of the death. Case referrals for committee evaluation include medically complex deaths when there are concerns regarding the medical care or if the clinical diagnosis, cause and/or manner of death is in question.

Review process

Case assignment occurs by aligning the practice profile and expertise of the committee members with the circumstances of the death. For example, paediatric deaths from a community setting will be reviewed by one of the community paediatricians. Similarly, the death of a neonate will be primarily reviewed by the neonatologist. The review process involves analyzing the existing record of the decedent. The record routinely includes medical records, the Coroner's Investigation Statement, the report of the Post Mortem Examination, toxicology report, police report and other relevant documents.

At the committee meetings, the primary reviewer presents the findings to the members for discussion. This provides an opportunity for discussion about issues that may have been identified through the review. The committee may also develop recommendations based on the findings of the review. The primary reviewer will compose a final report reflecting the committee's consensus opinion. The report, which will include the cause and manner of death and any committee recommendations, is provided to the referring Regional Supervising Coroner. If the

recommendations are systemic, the ministry, organization, agency or individuals are notified by the Committee Chair. Organizations are asked to respond back with the status of implementing the recommendation(s) within one year.

Where a case presents a potential or real conflict of interest for a committee member, that member will not participate in the review. Should a case require expertise from another discipline, an external expert will review and attend a PDRC meeting to participate in the discussion and drafting of recommendations.

Limitations

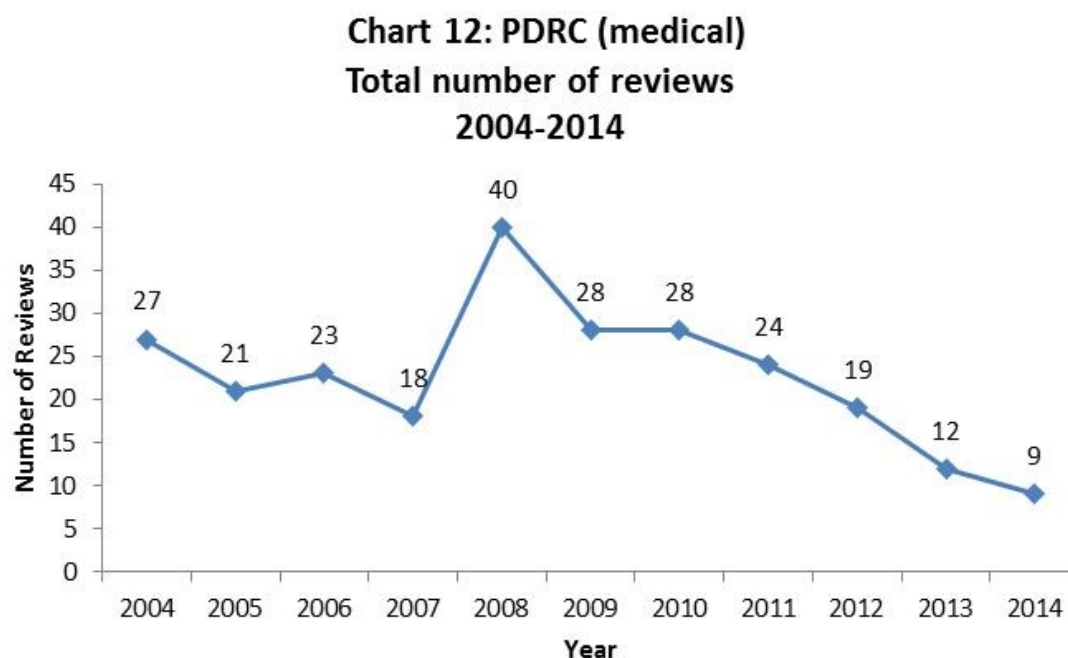
The PDRC is an advisory committee that makes recommendations to the Chief Coroner through the Chair. The PDRC case reports are prepared for the OCC and are governed by the Coroners Act, the Vital Statistics Act, the Freedom of Information and Protection of Privacy Act and the Personal Health Information and Protection of Privacy Act.

The consensus report of the committee is limited by the data provided. While efforts are made to obtain all relevant data, it is important to acknowledge that these reports are generated from a review of the written records. Sometimes the coroner/Regional Supervising Coroner conducting the investigation may have received additional information not included in the records that may render one or more of the committee's conclusions invalid.

Recommendations are made following a careful review of the circumstances of each death; they are not intended to be policy directives.

Statistical Analysis for Paediatric Death Review Committee – Medical

The number of PDRC – Medical reviews varies from year to year. The number of case reviews conducted by the PDRC Medical from 2004-2014 is reflected in Chart 12:



Analysis of 2014 Case Reviews PDRC – Medical

In 2014, a total of nine cases were reviewed by the PDRC – Medical. Seven of these cases had care-related concerns and two involved a clinical review to inform clinical diagnosis, cause and manner of death.

Of the nine cases reviewed, four involved children under one year of age, two involved children aged one to four years, two involved children aged five to nine years and one involved a child between 10 and 14 years. Five of the cases reviewed were male and four were female.

Recommendations

One of the important benefits of PDRC – Medical review is informing medical systems through recommendations using a “no blame” approach. The focus is on preventing future deaths via:

- Systemic changes;
- Changes in professional practice; and
- Response to emerging trends.

Given the PDRC – Medical referral criteria, recommendations are commonly directed to health care facilities. The collective expertise of the committee provides comprehensive reports that can be helpful to inform a healthcare organization’s Quality of Care Review Process. The findings and recommendations in the reports create an opportunity for the organization to see the potential for improvement in its internal processes or policies to avoid similar outcomes in the future. In 2014, the reviews resulted in 13 recommendations.

Summary of 2014 recommendations made by PDRC – Medical

The 13 recommendations made from the nine PDRC – Medical reviews focused on the following themes and were addressed to the identified organizations:

Summary of 2014 recommendations made by PDRC – Medical

Organization(s) asked to respond to recommendation	Theme of recommendation(s)	Number of reviews where theme was identified
Health care organizations Treating Health Care Professionals	• Review of the death through a Quality of Care Review Process**	5
Regional Supervising Coroner	• Genetic counselling for family	3
Health care organizations Treating Health Care Professionals Oversight Committee	• Diagnosis and assessment	6
Health care organizations Children’s Aid Society Police Service	• Lessons learned case review • Review and explanation of case findings	5

Health care organizations	• documentation	2
Health care organizations	• policy and procedures	2
Professional Associations		
Health care organizations	• Review of the death through a Quality of Care Review Process	7**
Treating Health Care Professionals	• Lessons learned case review	1
Ministry of Health and Long Term Care	• To support systemic enhancement of paediatric transportation	1
Ontario Hospital Association		
Health Care Professional Regulatory Bodies	• Professional practice issues	1
	• Publication of case review as an educational opportunity	1
Family members of a deceased child	• To ensure testing is undertaken for potential heritable disorders in surviving relatives	2
	• To provide resources to assist with understanding of the medical cause of death	2
Death Investigation System	• Additional diagnostic testing	1
Professional Associations	• Development/expansion of clinical assessment approaches	2

One review resulted in no new recommendations.

**The type of review process is not defined by the committee allowing the health care organization to determine the forum most applicable to their needs

Themes arising during medical reviews

Themes are often identified in individual case reviews and sometimes patterns may emerge when similar issues are observed in other reviews. Over time, the PDRC – Medical has identified and compiled a number of themes that have been common in child death reviews. The benefit of having a thematic approach is that the recurring themes can become an agent for systemic change. Over the past number of years, there have been a number of initiatives stemming from PDRC – Medical recommendations that have enhanced paediatric health care in Ontario.

Themes from 2014 case reviews

The cases reviewed by the PDRC – Medical in 2014 were associated with five key themes. Some cases had more than one theme identified.

While these themes are consistent with past findings, by taking the extra step of evaluating for emerging trends, a refined focus for recommendations is taken with a view of systemic improvement instead of only considering the individual cases. The five consistent themes, and issues associated with each, are:

1. Treatment - Quality of Care

Treatment and/or quality of care were identified as themes in eight of the cases reviewed. Issues included:

- Vital signs not obtained/recorded;
- Abnormal vital signs not appreciated;
- Assessment/recording of fluid balance not undertaken;
- Incorrect diagnosis and subsequent intervention;
- Lack of adherence to established protocols; and
- Need for involvement of advanced paediatric expertise.

2. Differential Diagnosis

Differential diagnosis was identified as a theme in six of the cases reviewed. Issues included:

- Alternative diagnoses not considered;
- Potential confirmation bias limited consideration beyond the admitting diagnosis;
- Non-recognition or lack of appreciation of:
 - Symptoms
 - Laboratory tests
 - Diagnostic imaging
 - Patient response to treatment

3. Documentation

Documentation was identified as a theme in three of the cases reviewed. Issues included:

- Qualitative and quantitative limitations;
- Poor or illegible hand writing; and
- Thought process/rationale for clinical approach not provided.

4. Communication

Communication was identified as a theme in three of the cases reviewed. Issues included:

- lack of discussion of vital patient information:
 - between physicians at the time of transfer of care
- lack of attention/acknowledgement of expressed patient/parent concerns;
- ineffective transfer of discharge advice/instruction; and
- Limited parental appreciation of clinical information due to ineffective understanding or ineffective information provision.

5. Importance of Regular Training/Professional Development

The importance of regular departmental training to ensure current knowledge in medical protocols and procedures was identified in three of the cases reviewed.

PDRC – Medical: Case Example

This case was reviewed by the PDRC – Medical and illustrates the difficulties and challenges that can arise for health care practitioners when caring for paediatric patients.

On December 3, 2013, a two-year-old child attended at a walk-in clinic with a two day history of cough and fever. The child's temperature was 38.2C. A diagnosis of bilateral otitis media was made and a seven day course of Amoxil was prescribed.

On December 21, 2013, the child returned to the walk-in clinic reportedly with continued cough without fever over the month since the last visit. The temperature was 36 C. The chest was clear on examination. A chest X-ray demonstrated mild perihilar and peribronchial thickening. No pneumonia was present. Therapy for reactive airways (Ventolin and Flovent puffers) was initiated. Advice was given to return to the clinic in a week for review.

The child returned on December 28, 2013 with report that the cough was 50% improved. However the child was complaining of left sided ear pain. The child's temperature was 38.3 C with left sided acute otitis media documented. Diagnosis charted was left acute otitis media and reactive airways disease. Cefzil was prescribed and advice was provided for continuation of the Ventolin and Flovent puffers.

The child attended a paediatric clinic on January 4, 2014. Documented concerns were cough and fever. The electronic note outlined a two-three day history of fever with a wet, phlegmy cough. A recent diagnosis of acute otitis media was noted with continued antibiotic treatment. A past history of reactive airways and puffers was included. Further, it was noted that other family members were well. The child's immunizations were up to date. Documented examination findings were: Temperature 39.7 C, Heart Rate <100 and Respiratory Rate <20. The child was noted to have appeared well, alert and in no distress. The tympanic membranes were clear. Other notations included normal cardiac examination and that the chest examination found clear lungs. The diagnosis was provided as probable viral infection. No medication changes were suggested.

Terminal Events

On January 7, 2014 the child represented at the walk-in clinic with a three day history of fever and cough. It was reported that the child had grunty respirations the evening prior. The child was in respiratory distress with oxygen given. The temperature was 38.5C. Differential diagnosis was Influenza or pneumonia. Given the clinical state the child was transferred to hospital by ambulance.

The child arrived at the hospital emergency department at 1347 hours with STAT attendance of the emergency department physician. The paediatric service was quickly consulted and attended regarding respiratory distress. History documented no travel, no daycare exposure and no Children's Aid Society involvement. The child lived at home with his parents and a four year old brother. Vital signs were: Temperature 37.5 C, Heart Rate 164, Respiratory Rate 50, Blood Pressure 91/64 and oxygen saturation 89% in room air. The child was recognized as critically ill with tachypnea, tracheal tugging, indrawing, lethargy and grunty respirations. Air entry was decreased bilaterally. No wheezes or crackles were noted. The capillary refill time was recorded at 2-3 seconds. Initial laboratory testing results were:

- White Blood Cell Count (WBC) 1.0, Absolute Neutrophil Count 0.39, Hemoglobin 103, Platelets 184
- International Normalized Ratio (INR) 1.6
- Venous Blood Gases: pH 7.22
- Chest X-ray was reported to show bilateral infiltrates and loss of lung volumes

The child was intubated and placed on a ventilator at 1427 hours. Treatment included intravenous antibiotics (Ceftriaxone, Tazocin, Gentamicin); normal saline fluid bolus (20 cc/kg) and a Dopamine infusion. Arrangements were made to transfer the child to a tertiary care children's

hospital with dispatch of the transport team. During this time, the child developed bradycardia, which initially responded to CPR, epinephrine infusion and further normal saline boluses. A right internal femoral central venous line was inserted. Laboratory testing from 1440 hours revealed:

- Sodium 131, Potassium 4.1, Chloride 97, Bicarbonate 5, urea 16, creatinine 115, Liver Function tests: Aspartate Aminotransferase (AST) 77, Alanine Aminotransferase (ALT) 16, glucose 4.6, Creatine Kinase 55, Lactic Acid 5.1
- Arterial Blood Gases: pH 7.05, pCO₂ 68, PO₂ 239, Bicarbonate 19

The team from the tertiary care children's hospital arrived, but persistent bradycardia continued despite resuscitative measures and the child was declared deceased at 1812 hours.

Post Mortem Findings:

1. Bilateral extensive pulmonary consolidation
2. Fibrino-purulent pleuritis with purulent pleural effusions, bilateral—total amount--200 ml
3. Positive cultures for Streptococcal pneumoniae from multiple sites: Blood (pre/post mortem); lung, nasopharyngeal, middle ear ; Antibiotic sensitivity only to Vancomycin
4. Lung tissue positive for viruses: Influenza A and HHV6 by Polymerase Chain Reaction(PCR) testing
5. Recent changes of hypoxic-ischemic encephalopathy
6. Pre-mortem PCR positive testing of nasopharyngeal swab for H1N1 subtype of Influenza A

Cause of Death:

- Septic Complication of Acute Bronchopneumonia due to Streptococcal pneumoniae
- Contributing Factor: H1N1 Influenza A infection

Manner:

- Natural

Comments and Issues Raised

Bacterial superinfection of the lung is a well described complication of H1N1 Influenza A infection. This is reported in 4-29% of hospitalized or death cases. Of particular note there is an association with pneumococcal disease.

No concerns were identified about the care and management at the emergency department.

At the paediatric clinic, the vital signs were documented as within a range with a cut off level (< 100). The report of a heart rate as less than 100 in a child with a temperature of 39.7 C is surprising. The child presented with an apparent acute febrile illness with a history of reactive airway disease. The clinical picture did not include typical signs/symptoms of an upper respiratory tract infection and a source for the fever was not identified. Streptococcal pneumonia infection is associated with H1N1 Influenza A and will typically have a biphasic acute illness presentation. Fragmented clinical care provision arising from attendance with different medical care providers may contribute to challenges in identifying alternative diagnoses.

This case illustrates that preventative measures such as yearly Influenza vaccination remain important for children and the general public to prevent disease. The Canadian Paediatric Society recommends that all children under six years of age be considered for Influenza vaccination.

Recommendations

1. The paediatric clinic should undertake a lesson learned case review with focus upon:

- a. Approach to vital sign interpretation within the context of clinical presentation
- b. Approach to vital sign charting
- c. Consideration for alternative diagnosis

Paediatric Death Review Committee – Child Welfare

Child welfare services in Ontario are provided by 47 Children's Aid Societies (CAS), nine of which are designated Aboriginal agencies. Each CAS is an independent, not-for-profit agency governed by a board of directors[2]. CASs receive provincial funding from the Ministry of Children and Youth Services (MCYS).

By policy, coroners in Ontario investigate all paediatric deaths where a CAS has been involved with the child, youth or family within 12 months of the death. In 2006, the OCC and the MCYS implemented a Joint Directive on Child Death Reporting and Review. The Directive outlines the process CASs must follow when reporting and reviewing child deaths when they have been involved with the child, youth or family within 12 months of the death (see Appendix A for more information).

Stemming from the process outlined in the Directive, there are three distinct information sets that are relevant to CASs, the government and the public, resulting from:

1. The death investigation by the coroner;
2. CAS reporting related to these deaths; and
3. PDRC - Child Welfare reviews completed in certain circumstances.

This annual report presents an analysis of this information, to support data driven public safety, by:

- Comparing paediatric deaths with CAS involvement to paediatric deaths without CAS involvement;
- Conducting an analysis of data about paediatric deaths where there has been CAS involvement; and
- Providing recommendations in an effort to prevent future deaths in similar circumstances.

Prior to 2014, the PDRC – Child Welfare's annual report focused on an analysis of PDRC case reviews. More can be learned from considering all paediatric deaths with CAS involvement, using the information provided by CASs in relation to those deaths. For this reason, this year's annual report takes the same approach as in the report released in 2014.

The PDRC – Child Welfare and the OCC continue to believe that this data is valuable to gain a better understanding of paediatric deaths with CAS involvement in Ontario. After the publication of last year's annual report, the OCC received feedback from many parties about the value of the approach and the increased utility of the information. It is hoped that this additional analysis will continue to assist CASs, policy makers, researchers and the public to identify relevant areas to develop strategies and policies that help to prevent future deaths in similar circumstances.

Use of data by the PDRC – Child Welfare

In 2014, the OCC continued its work to address challenges with the data. Many of the factors regarding the data available for PDRC analysis that were considerations in 2013 continued to be factors in 2014, including but not limited to:

- The data continues to be primarily collected by coroners from across the province. Limits in standardization and non-confirmation of data accuracy may affect the analysis. The OCC is developing a new data capture computer system that is expected to significantly improve the quality and completeness of the OCC's data.
- There continues to be variable presentation of data provided by CASs to the PDRC. Data collection would benefit from a standardized set of definitions and a common format to support consistent data collection. This work is being held until the new model of child death review is developed, to avoid potential duplication of efforts.
- The lack of comparator data from other sources. Data from different sources is collected with varying sets of parameters, depending on the needs of the organization. Some of the data required for effective comparison is unavailable. Other data sets are incomplete, or measured in ways that do not align with the data that the OCC and the PDRC collect. The OCC is engaging with multiple stakeholders inside and outside of the Government of Ontario, to explore opportunities for data sharing.
- There are varying interpretations of the Joint Directive on Child Death Reporting and Review. We are not proceeding with clarification of the Joint Directive at this time, pending the development of a new model of child death review, to avoid potential duplication of efforts.

Where comparison between the 2013 and 2014 data sets was feasible, the results have been included in the report. The two years of data analyzed to-date suggests that there is sufficient variability within the data year-over-year to merit the ongoing examination of the data prior to drawing any conclusions. As time passes and larger data sets are developed the ability to identify trends or draw conclusions from the data will improve. At this time, the significance of available data is unknown.

PDRC – Child Welfare's Approach to Statistical Analysis

As in 2013, the chi-square goodness-of-fit test was used to determine how "close" observed rates of paediatric deaths are to that expected in the context of one of two standard populations – paediatric coroner's investigations, or child deaths in Ontario. In others, the Fisher's exact test was used to examine the association between two variables.

In some cases, no statistical analysis could be completed because of limitations arising from the nature of the data, the size of the populations, or challenges with data as discussed above.

In this section of the annual report, basic statistical analyses have been utilized to support the presentation of available data. In the future, additional data analysis is anticipated.

2014 Paediatric Deaths with CAS Involvement Compared to Other Paediatric Deaths in Ontario

In 2014, there were 1,028 paediatric deaths in Ontario (aged 0 – 18 inclusive). Of these, 38% (387) met the criteria for coroners' investigation and the majority of deaths, 62% (641) did not.

Of the 387 coroners' investigations, 109 had involvement the CAS within 12 months of the death and were reported by a CAS to the PDRC – Child Welfare, accounting for 28% of all paediatric coroners' investigations. This is consistent with data from previous years.

MCYS does not collect data on the number of children and youth that receive services from CASs in the community. Instead, the number of families served by CASs is reported, so it is not possible to determine whether the rate of paediatric deaths in Ontario is the same as, or different from, the rate of paediatric deaths in the population of children and youth served by CASs.

PDRC – Child Welfare Analysis: Understanding the role of Natural Deaths with Child Welfare Involvement and Deaths Still Under Investigation

By policy, coroners in Ontario investigate all paediatric deaths that occur where CAS has been involved with the child, youth or family within 12 months of the death. Consequently, some paediatric deaths that would not ordinarily meet the criteria for a coroner's investigation are investigated solely because of the involvement of CAS. These deaths include natural deaths occurring in hospital that under normal circumstances would not likely be investigated by a coroner. In 2014, 29 coroner's investigations fell into this category. These 29 deaths have been excluded from some of the analysis undertaken in this report to allow for comparison against the broader population of paediatric coroner investigations (which does not include natural hospital deaths free of other concerns).

In addition, two cases are still under investigation and have been excluded from analysis for this reason. One of the two cases had child welfare involvement within 12 months of the death. Therefore, in some analyses, the total number of coroner investigations of paediatric deaths is reflected as $356 (387 - 29(\text{natural}) - 2(\text{under investigation}) = 356)$, with the total number of paediatric deaths with CAS involvement reflected as $79 (109 - 29 - 1(\text{under investigation}) = 79)$. This is consistent with the approach taken in 2014.

Coroner's Cases with CAS Involvement Compared with Coroner's Cases without CAS Involvement – Gender and Age

Consistent with previous years, the association between male and female paediatric decedents investigated by a coroner, with and without CAS involvement, was not statistically significant^[3]. In other words, there was no significant relationship between gender and the prior involvement of a CAS with paediatric decedents that were the subject of coroner investigations.

Chart 13 demonstrates the proportion of paediatric deaths across age groups in Ontario overall, compared to coroner investigations with and without CAS involvement.

The number of deaths with CAS involvement was compared to the number of coroner investigations without it, across age groups^[4]. The number of CAS involved deaths across age groups differed from what would be expected if the CAS involved population was the same as population of paediatric deaths that are the subject of a coroner investigation without CAS involvement.

The 2014 data, within the context of limitations noted earlier, demonstrated that 1-4 year old decedents were more likely to have CAS involvement prior to their death and 15-18 year old decedents were less likely to have CAS involvement prior to their death. There was no significant difference in other age groups.

The 2013 data demonstrated that the 5-9 year old decedents were more likely to have CAS involvement prior to their death and 15-18 year old decedents were less likely to have CAS involvement prior to their death.

The proportion of deaths across age groups was consistent from 2013 to 2014.

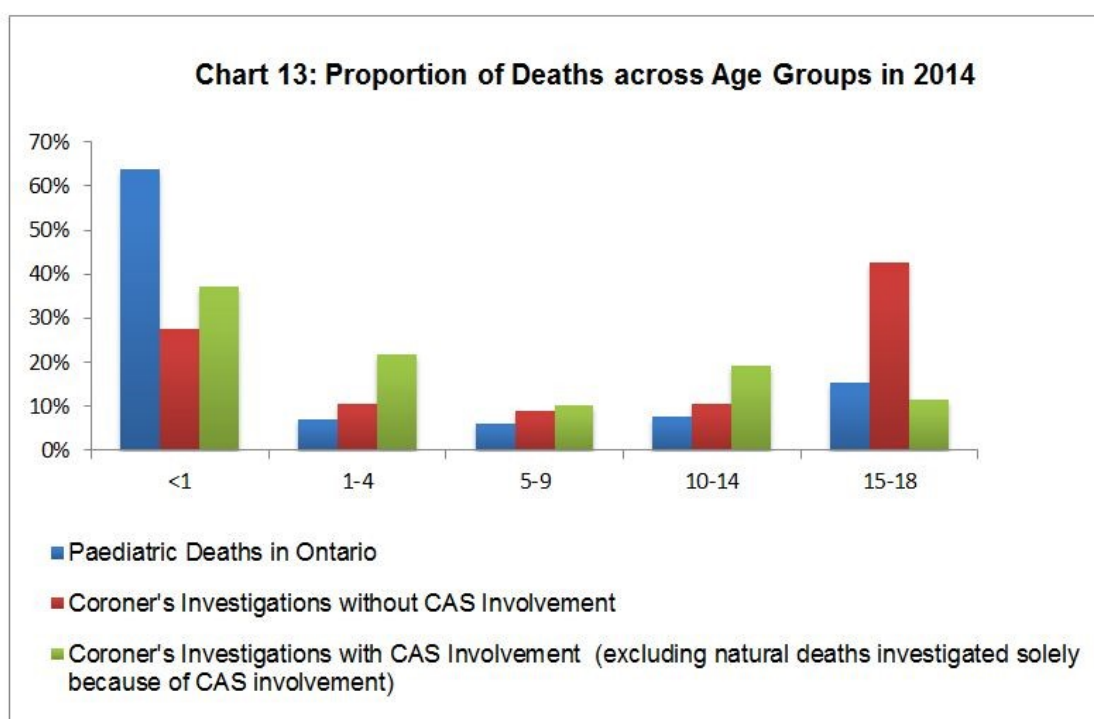


Chart 14 illustrates that the percentage of paediatric deaths occurring in each region of the province is almost the same as the percentage of children and youth across Ontario, by region. However, analysis of the available data shows that there is a significant difference between the number of deaths with CAS involvement occurring in each region and the number of child and youth deaths in Ontario overall occurring in each region^[5].

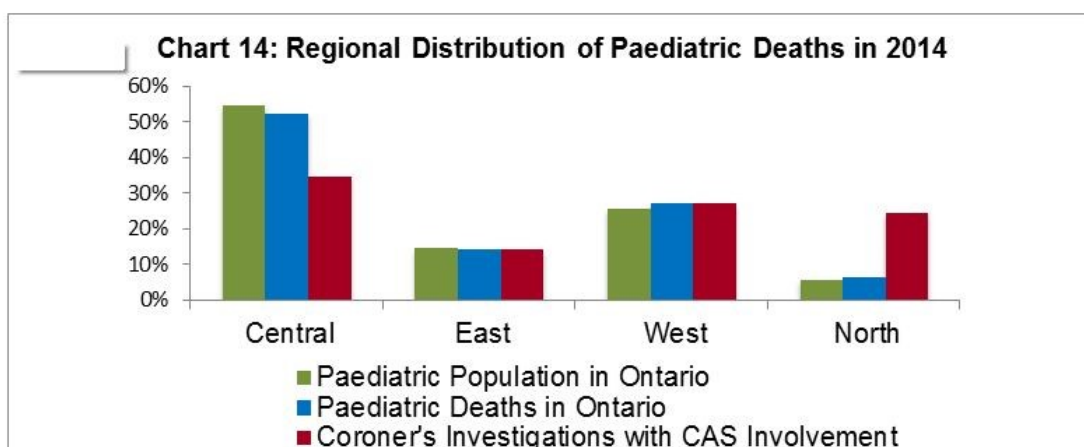
Fewer deaths with CAS involvement appear to occur in the Central region, when compared to the overall number of child deaths in Ontario.

As in 2013, in 2014 the data continue to suggest that more deaths with CAS involvement occur in the North when compared to the overall number of child deaths in Ontario. Six per cent of paediatric deaths in Ontario occurred in the North, while 24% of paediatric deaths with CAS involvement occurred in that region.

As we noted in the 2014 Annual report, there are a number of potential reasons that may be associated with the apparent overrepresentation of child and youth deaths in the North, including but not limited to: lower health status, challenges to accessing healthcare services and higher mortality rates that increase with remote place of residence^[6].

In 2014, available data indicated that 73% of the deaths with CAS involvement that occurred in the North region were Aboriginal children and youth. This is consistent with 2013 data. In the absence of comparator data on the number of individual children and youth served by CASs across the various regions, it is not possible to determine whether this information may reflect higher rates of child welfare service delivery in the North, or some combination of other variables.

Notably, 14% of all paediatric coroner investigations took place in the North – greater than the percentage of paediatric deaths in that region (6%), and less than the percentage of paediatric deaths with CAS involvement in that region (24%). This may suggest that the higher percentage of paediatric deaths with CAS involvement in the North relative to other regions may arise from a combination of several factors.



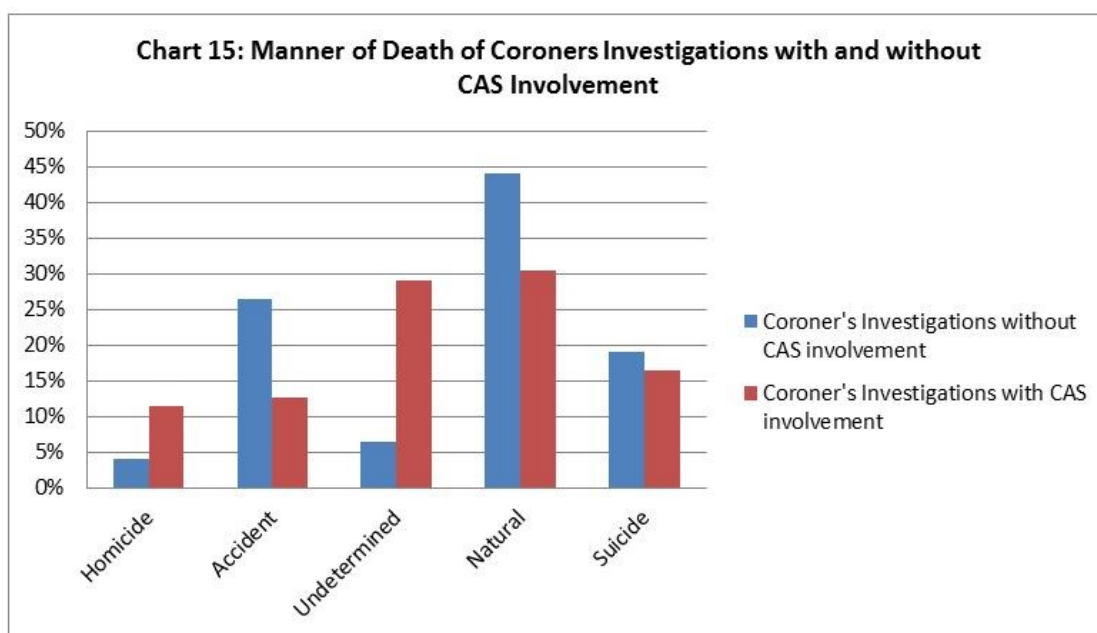
* The Ministry of Community Safety and Correctional Services Central Region includes Toronto.

Manner of Death – Coroner's Cases with CAS Involvement Compared with Coroner's Cases without CAS Involvement

The manner of death indicates how children and youth in Ontario die. If the well-being of children and youth across Ontario, with or without CAS involvement, were equal, it would be expected that the number of paediatric deaths occurring from a given manner of death would be the same in each category.

It is recognized that vulnerable children and youth receive services from CASs. The manner of death may provide valuable insight into the impact of services provided, but it cannot be used as an indicator of the effectiveness of service to the exclusion of many other indicators because CASs provide services in the broader context of a number of variables, and are generally not the only service providers engaged with this population of children and youth.

A significant difference was noted between the number of deaths with CAS involvement compared to the number of deaths investigated by a coroner without CAS involvement, by manner of death⁽⁷⁾. Chart 15 illustrates that in 2014, homicides and undetermined deaths appear to be more prevalent where a CAS was involved with the child, youth or their family prior to the death, while accidents and natural deaths appear to be less prevalent. Deaths occurring as a result of suicide were neither more nor less likely to occur with CAS involvement. This data varies from the 2013 data, which indicated that natural deaths and deaths occurring as a result of homicide, suicide or accident were neither more nor less likely to occur with CAS involvement, and that circumstances where the manner of death was undetermined appeared to be more prevalent where a CAS was involved with the child, youth or their family prior to the death. This variance may be representative of year to year variation within a relatively small data set.



What do we know about deaths where the manner of death is undetermined?

When a complete investigation, including an autopsy, review of the clinical history and evaluation of the scene, does not allow for identification of a specific manner of death, or there are competing manners of death, the death will be classified as undetermined. Most paediatric deaths that are classified as undetermined occur in children under one year of age, with a smaller proportion occurring in children under five and even fewer in the older age group (see Chart 16).

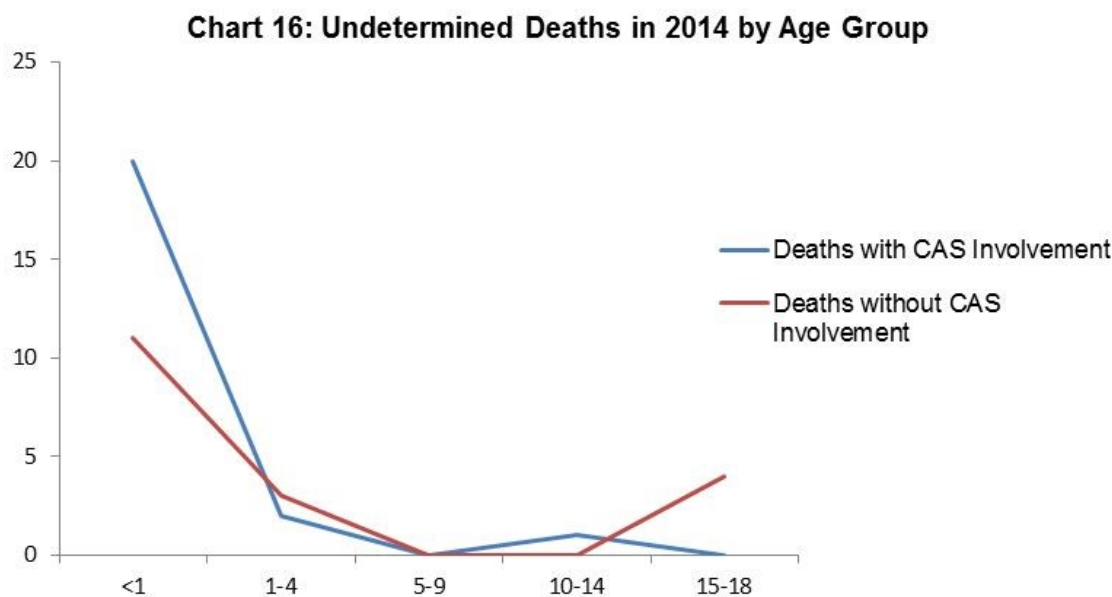
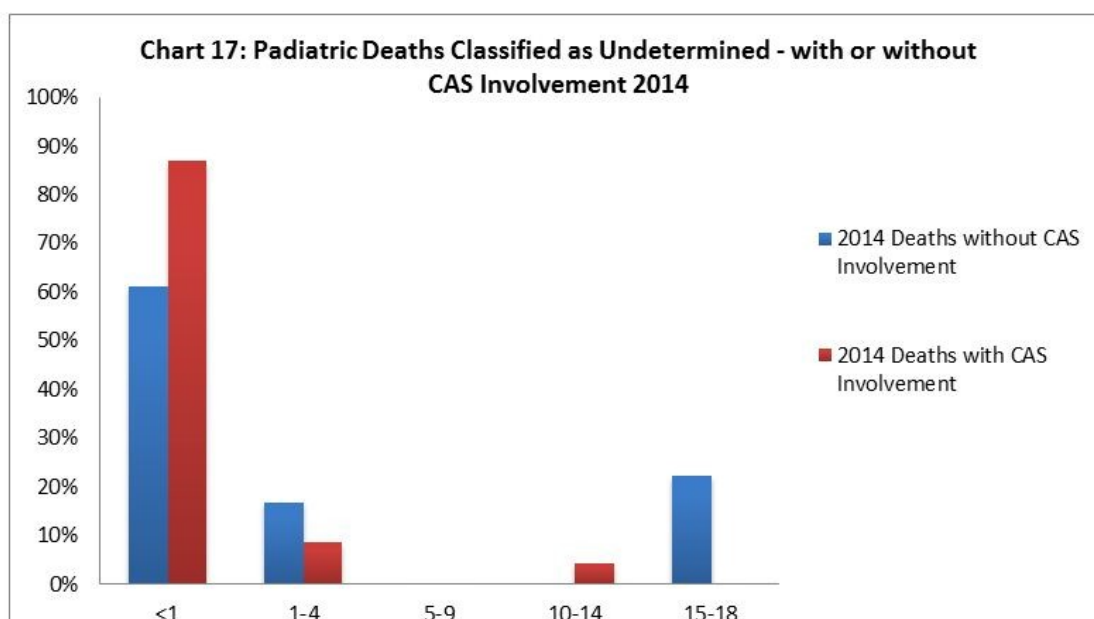


Chart 17 shows the percentages of undetermined deaths in each age category, with and without CAS involvement prior to the death. Among cases where the manner of death is undetermined, the 2014 data demonstrates a statistically significant difference in the number of deaths of children with and without CAS involvement[8]. This difference is most notable in the number of deaths of children under the age of one. In 2013, the data showed that there was no significant difference resulting from the involvement of a CAS within particular age cohorts[9].



Presence of Sleep Associated Circumstance as a Potential Contributing Factor in Undetermined Deaths

In 2014, sleep circumstances were identified in 63% (26) of the 41 paediatric deaths where the manner of death was classified as undetermined. 62% (16) of these children or their families received services from a CAS within 12 months of their death, and 38% (10) did not.

While the data demonstrates a statistically significant difference in the number of deaths of children with and without CAS involvement where the manner was undetermined, when considering only those cases where sleep circumstances were identified as potential contributing factors to the death there was no significant difference between CAS involved and non-CAS involved populations^[10]. This is consistent with findings in 2013.

As noted in the 2014 Annual Report, many variables require consideration in interpreting this finding. For example, CASs are not the only organizations promoting safe sleep environments in communities. The independent impact of CAS practice on the number of paediatric deaths occurring in unsafe sleep environments is unknown; however, the continued absence of a significant difference between CAS involved deaths and those without CAS involvement may suggest that the practices of CASs have potentially contributed to the overall prevention of paediatric deaths where sleep environment may be factor.

2014 Deaths with CAS Involvement – Status of Children and Youth

88% (96) of the children and youth that died in 2014 where a CAS was involved with the child, youth or family within 12 months of the death were not in the care of a CAS.

11 children or youth were in the care of a CAS – six were Crown wards, one was a Society ward, two were subject of temporary care agreements and two were the subject of customary care agreements. One youth aged 18 and under, was receiving Continued Care and Support for Youth (CCSY) (formerly Extended Care and Maintenance) support.

What does the available data tell us?

*Information provided by the CASs from Child Fatality Case Summary Reports supports a greater understanding of the circumstances surrounding the deaths of children and youth. In particular, the information helps to illuminate particular risks and vulnerabilities.

- In 2014, approximately 80% of cases where a child or youth that had been receiving services from a CAS were open files at the time of death (see Chart 18), as compared to approximately 70% in 2013.
- Almost 40% of the cases were rated as high risk at the time of death (see Chart 19). The Ontario Child Protection Standards released in February 2007 require that "Cases with a high or very high risk rating, or where a safety plan is being managed and the child continues to reside in the home, should receive more intensive service (frequency of visits)" (Standard 10, p. 71). Requirements of the Standards would suggest that in these cases, the CAS would have been engaging with the family with some frequency prior to the death.
- Verified abuse and neglect of the child or youth that died and/or their sibling continued to be the most commonly reported vulnerability factor (see Chart 20). 30% of CAS reports regarding the deaths of children and youth in 2014 indicated that the child or youth had been the subject of verified abuse or neglect, and 39% indicated that a sibling of the child or youth had been the subject of verified abuse or neglect. In 19% of cases, both of these vulnerability factors were present.
- Disabilities are the second most commonly reported vulnerability factor (see Chart 20). 27% of the children and youth that died had physical disabilities, and 21% of them had mental or emotional disabilities. In 10% of cases, both of these vulnerability factors were present. Chart 20 provides a comparison of 2013 and 2014 data on vulnerability factors reported by CASs.
- Suicide was found to be the manner of death for 13 youth receiving services from a CAS. Of these, four were Aboriginal children and youth. There are three known or suspected vulnerability factors related to suicide reported on the Child Fatality Case Summary Report by CASs – child/youth has previously attempted suicide, recently experienced the suicide of a friend or relative, and/or had spoken to someone about suicidal thoughts. For five of the 13 youth, there was more than one of these vulnerability factors present. Four of the youth had previously attempted suicide, two of the youth had recently experienced the suicide of a friend or relative, and seven had previously spoken to someone about suicidal thoughts.

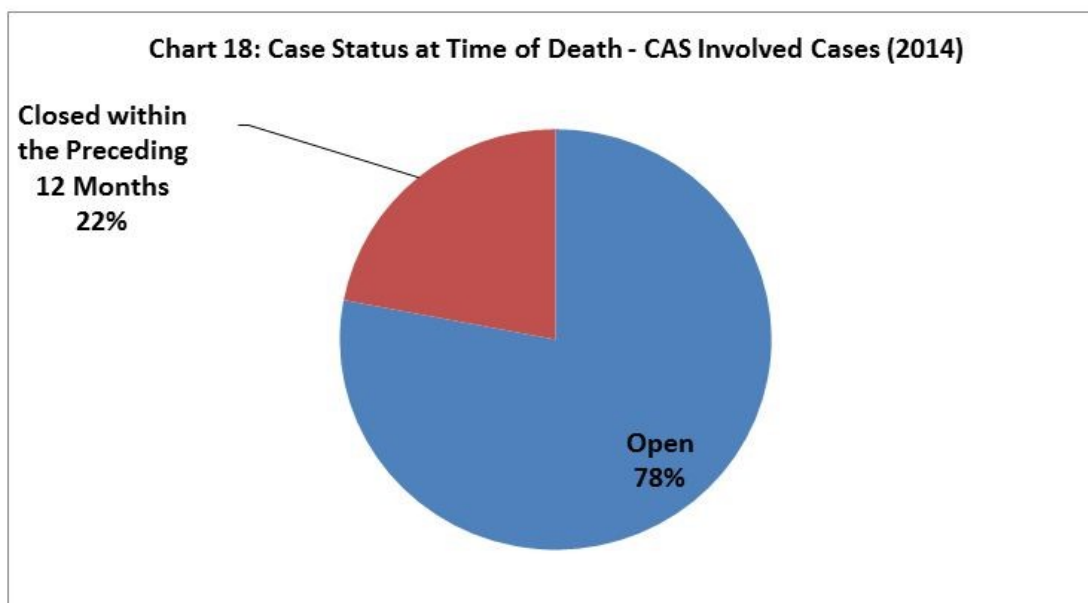


Chart 19: Overall Risk Rating at Time of Death/ Case Closure- CAS Involved Cases (2014)

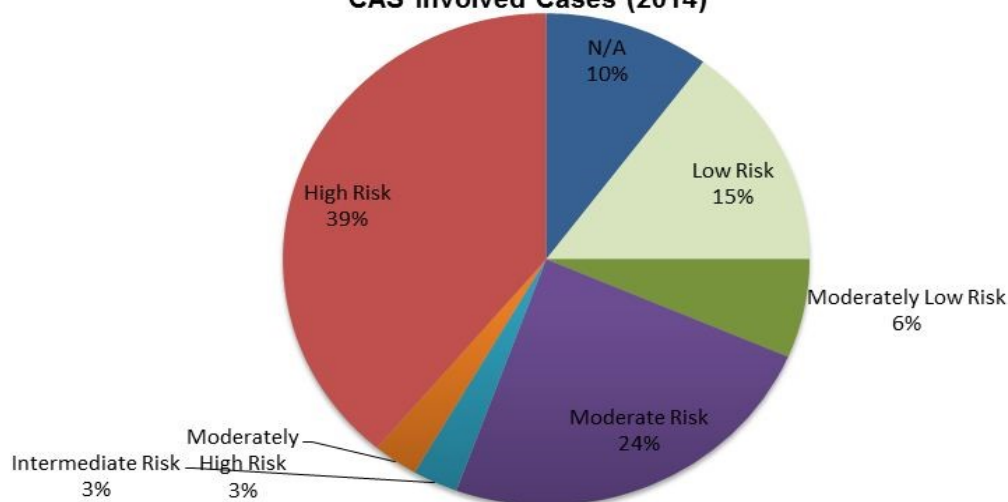
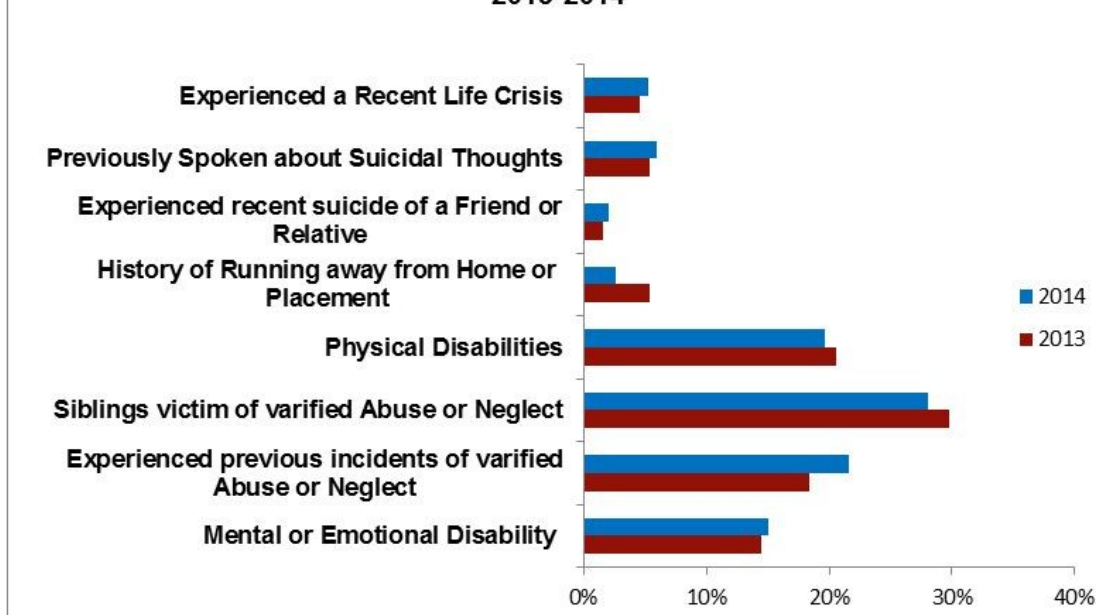


Chart 20: Known Vulnerability Factors- CAS Involved cases 2013-2014



While the information that the CAS provides when a child or youth dies can be valuable in identifying particular vulnerability factors, there may be other risk factors for children and youth that are not reported through the Joint Directive reporting process. This is because all potential risk factors for children and youth in Ontario are not collected in a standardized way. Furthermore, the factors collected should not be construed as unique to children and youth that have died, or to children and youth that were receiving the services of a children's aid society. It is not known whether the prevalence of identified factors is different in the population of children and youth that have died as compared to the living population of children and youth in Ontario, or receiving services from a children's aid society.

Deaths of Aboriginal Children and Youth with Children's Aid Society Involvement Investigated by the Office of the Chief Coroner in 2014

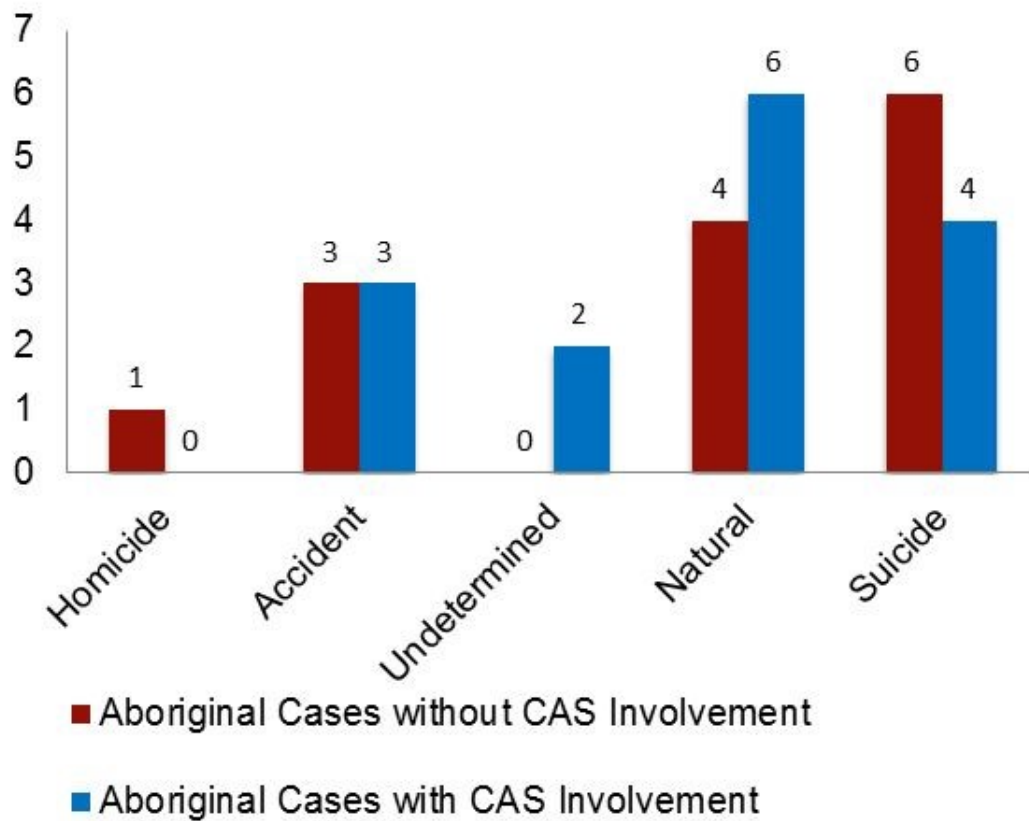
The ability to undertake meaningful analysis of the deaths of Aboriginal children and youth served by CASs is affected by the limited data available to the OCC. The coroner may not identify children and youth as Aboriginal as they rely on the information available in the course of their investigation (information sources include but are not limited to family members, community service providers, the police). This affects the determination of the true number of Aboriginal children and youth whose deaths were investigated by the OCC in 2014. In addition, the number of deaths of Aboriginal children and youth where a CAS has been involved is small, preventing meaningful statistical analysis. Furthermore, the data available from other sources has limitations (for example, CASs do not report ethnicity).

The available data has been provided; however, given the noted limitations, meaningful inferences cannot be made. In the future, the OCC and PDRC – Child Welfare hope that the quality and availability of data on Aboriginal children and youth may be enhanced to support analyses that may inform prevention strategies targeted to Aboriginal children and youth.

What does the available data tell us?

- Of the 29 coroner investigations into deaths of Aboriginal children and youth, 15 (51%) were Aboriginal children and youth that had received the services of a CAS within the 12 months prior to their death.
- Of 20 deaths where the CAS had been involved with the child, youth or their family within 12 months of the death in the North Region, 14(70%) were identified as Aboriginal children and youth.
- Of the 15 Aboriginal children and youth that had received the services of a CAS within the 12 months prior to their death, 13 were involved with designated Aboriginal children's aid societies. The other two were involved with non-Aboriginal CASs. Children and youth are served by designated Aboriginal CASs when they reside in an area of Ontario in which a designated CAS has jurisdiction.
- Of the 12 coroner investigations into the deaths of children and youth in the care of a CAS or in receipt of Continued Care and Support for Youth (formerly Extended Care and Maintenance) two were Aboriginal children and youth. Both of these youth were the subject of customary care agreements. None of the Crown wards (six) that died in 2014 were Aboriginal children and youth.
- The number of deaths of Aboriginal children and youth that had involvement of a CAS is too small to allow analysis of the manner death. Chart 21 provides available information on the manner of death of these 29 children and youth. When compared with 2013 data, there is little consistency in terms of the proportion of deaths attributable to any one manner from 2013 to 2014.

Chart 21: Comparison of Manners of Death of Aboriginal Children and Youth in 2014



Children and Youth in the Care of a CAS or Receiving CCSY at the Time of Death

Chart 22 illustrates that 11 children and youth in the care of a CAS at the time of their death, along with one youth receiving CCSY, ranged in age from 16 days of age to 18 years.

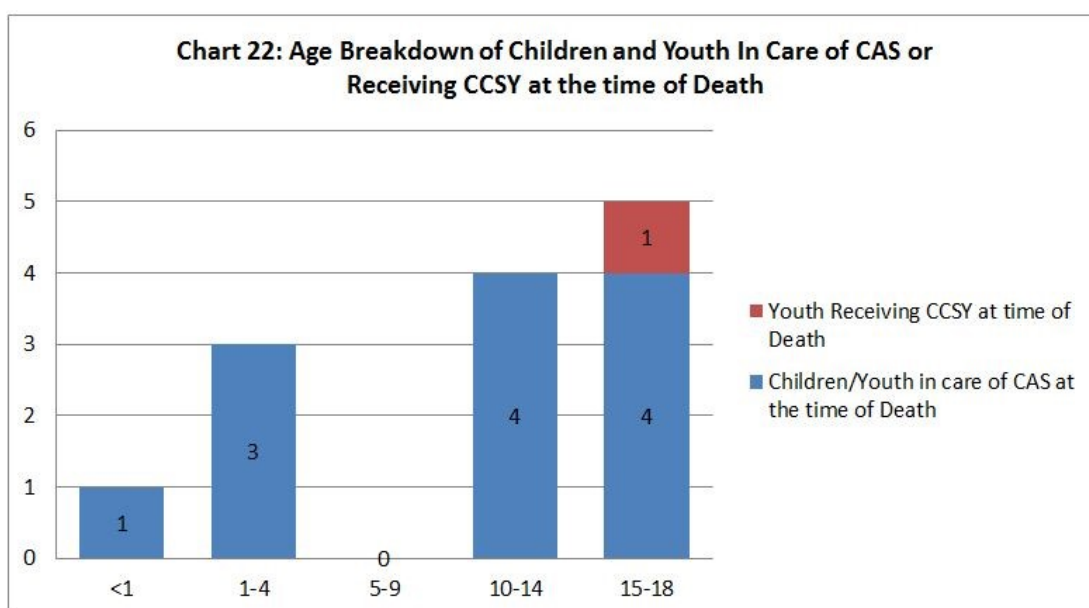
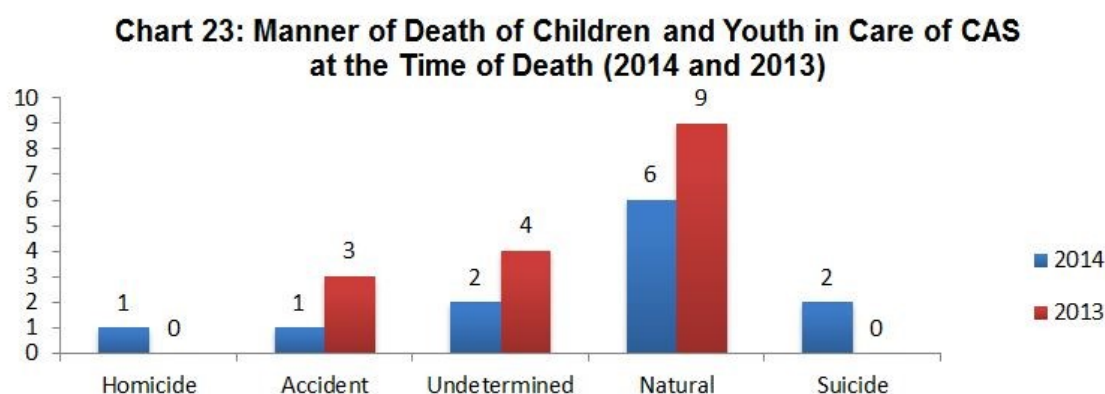


Chart 23 shows the manners of death of Children and Youth in Care or Receipt of CCSY in 2013 and 2014. In each year, more than 50% of the deaths of children and youth in care were classified as natural deaths.



PDRC – Child Welfare Reviews of Cases with Children’s Aid Involvement in 2014

All child deaths are tragic and typically have a number of contributing factors. Occasionally, the actions or inactions by those in a care-giving role (e.g. family members or the child welfare system) may have played a part in the circumstances of the death. The PDRC – Child Welfare reviews the circumstances of the death and may make recommendations to the health care sector, child welfare systems and others with a goal to reduce the number of child deaths and/or to improve the services and care provided to families. It is anticipated that by examining these cases in a non-blaming manner, we can learn from these deaths to improve the lives of other children in the future.

Reports Received by the PDRC – Child Welfare in 2014

PDRC – Child Welfare cases reported to the Committee are usually not reviewed within the same calendar year as the year in which death occurs. Committee reviews in any given year will include review of deaths occurring in different years (see Chart 25). . This results from a number of

factors, including: complexity of the investigation, time allotment for completion of other reviews (for example, DU5C), case volume, and other parallel investigations or proceedings, including involvement of the criminal justice system.

In 2014, as required by the Joint Directive, 109 deaths of children and youth aged 0-18, where the child and/or family had CAS involvement within 12 months of the death, were reported by a CAS to the PDRC. These cases are at various stages of the PDRC review process.

Chart 24: PDRC Status of 2014 Deaths with CAS Involvement

Chart 24 illustrates the status of review for the 109 cases reported to the PDRC – Child Welfare in 2014. 69% of cases do not undergo a full PDRC review. This is consistent with 2013 data.

Chart 24: PDRC Status of 2014 Deaths with CAS Involvement

Status	Number of Cases
Closed A PDRC Executive Review has taken place, and no full PDRC review is planned. This occurs when the circumstances surrounding the child's death do not relate in any way to the reasons for services and/or the CAS involvement.	75 (69%)
Pending Decision Cases may be pending a decision regarding PDRC review because additional information is required or because there are other pending investigations or criminal justice system involvement	5 (5%)
Full PDRC Review to be Undertaken An internal child death review has been requested from the CAS, and the PDRC will undertake a full review of the case.	15 (14%)
Full PDRC Review Completed An internal child death review was requested from the CAS, and the PDRC has undertaken a full review of the case.	14[11] (13%)

Reports Reviewed by the PDRC – Child Welfare in 2014

In 2014, following the process outlined in Chart in Appendix A, the PDRC - Child Welfare reviewed the deaths of 28 children and youth who had involvement with CAS within the 12 month period leading up to their deaths. Chart 25 identifies the year the death occurred for the 28 cases reviewed.

Chart 25 illustrates the year the death occurred for the cases reviewed by the PDRC – Child Welfare in 2014. The year of death for those cases reviewed in 2014 ranged from 2010 – 2014. The majority (15) of the 28 cases reviewed in 2014 were deaths that occurred in 2013.

Chart 25: Year of death of 2014 PDRC Case Reviews

Chart 25: Year of death of 2014 PDRC Case Reviews

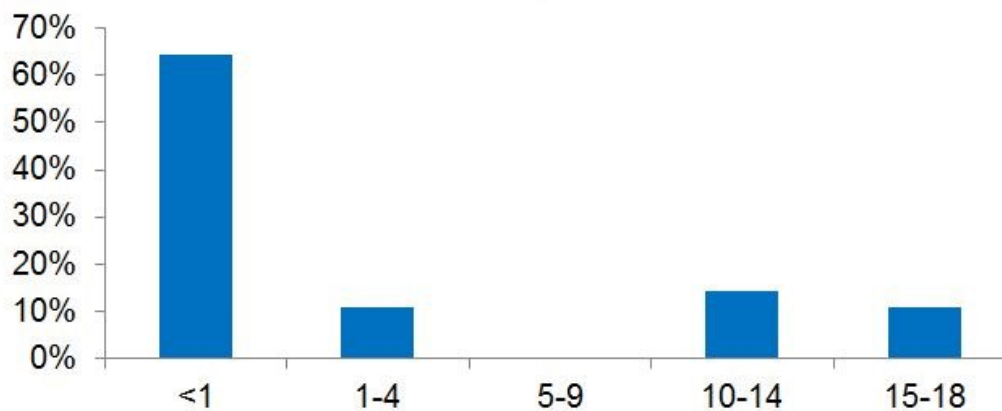
Year of Death	PDRC Cases Reviewed
2010	1

Year of Death	PDRC Cases Reviewed
2011	2
2012	5
2013	15
2014	5
TOTAL	28

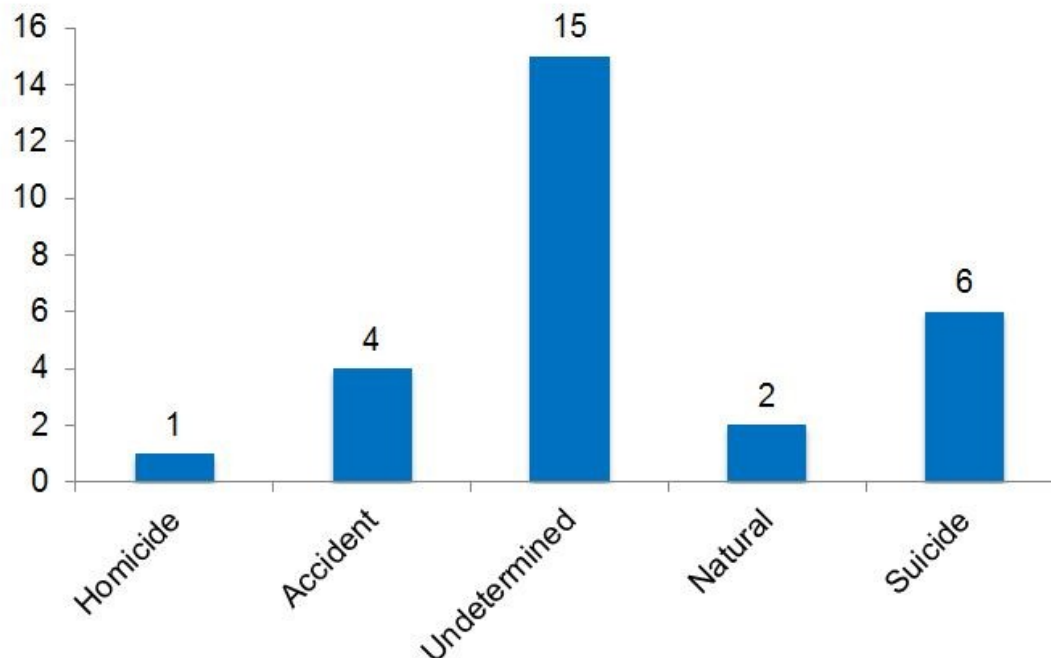
Sixteen of the children and youth were male (57%) and 12 were female (43%).

The age of the children and youth ranged from 18 days to 16 years. Historically, a greater proportion of reviews completed by the PDRC – Child Welfare involve children under one and adolescents. Chart 26 demonstrates the age categories for the cases reviewed. This information illustrates that in 2014 the PDRC – Child Welfare continued to focus upon deaths of children under the age of one and older children and youth.

Chart 26: PDRC- Child Welfare Reviews Across Age Groups (2014)



The manner of death of children and youth whose cases were reviewed by the PDRC – Child Welfare in 2014 are identified in Chart 27.

Chart 27: Cases Reviewed by PDRC- Child Welfare (2014)

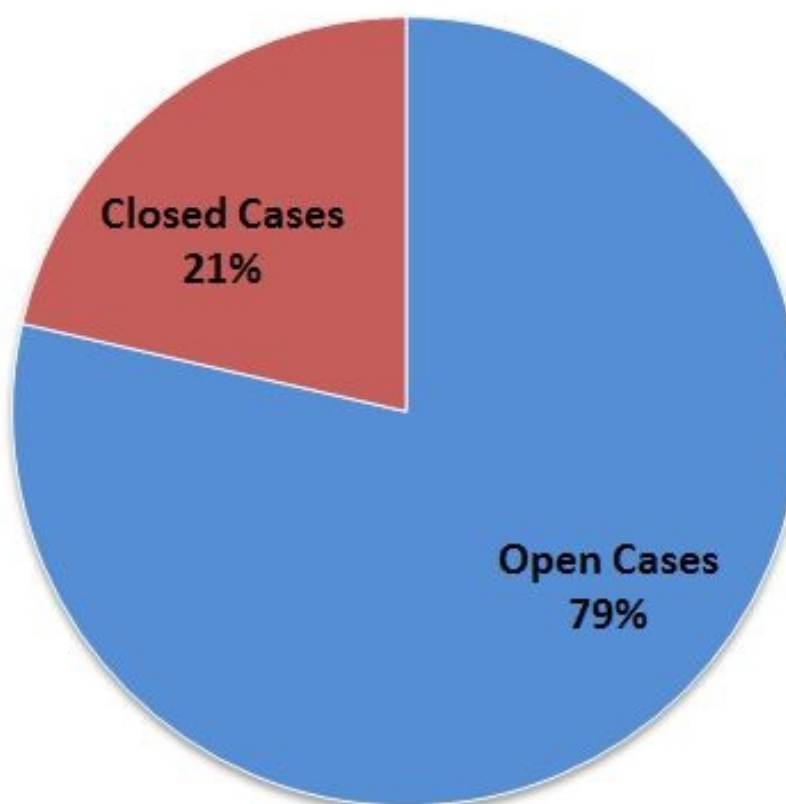
Of the 15 deaths reviewed by the PDRC – Child Welfare in 2014 where the manner of death was undetermined, sleep circumstances were identified as a potential contributing factor in 12 cases (80%).

Of the 28 cases reviewed by the PDRC – Child Welfare in 2014, 79% (22) were open to the CAS at the time of death (see Chart 28).

Of the 22 cases open to the CAS, three cases were open at intake and one was the subject of a supervision order. Two children and youth were in the care of the CAS at the time of their death – one was the subject of a Temporary Care Agreement and one was a Crown ward.

The manner of death for the two children and youth in care was suicide and undetermined.

Chart 28: PDRC- Child Welfare Cases Reviewed in 2014- Open vs Closed



PDRC – Child Welfare Case Reviews in 2014 – Analysis of Factors Identified through Case Reviews

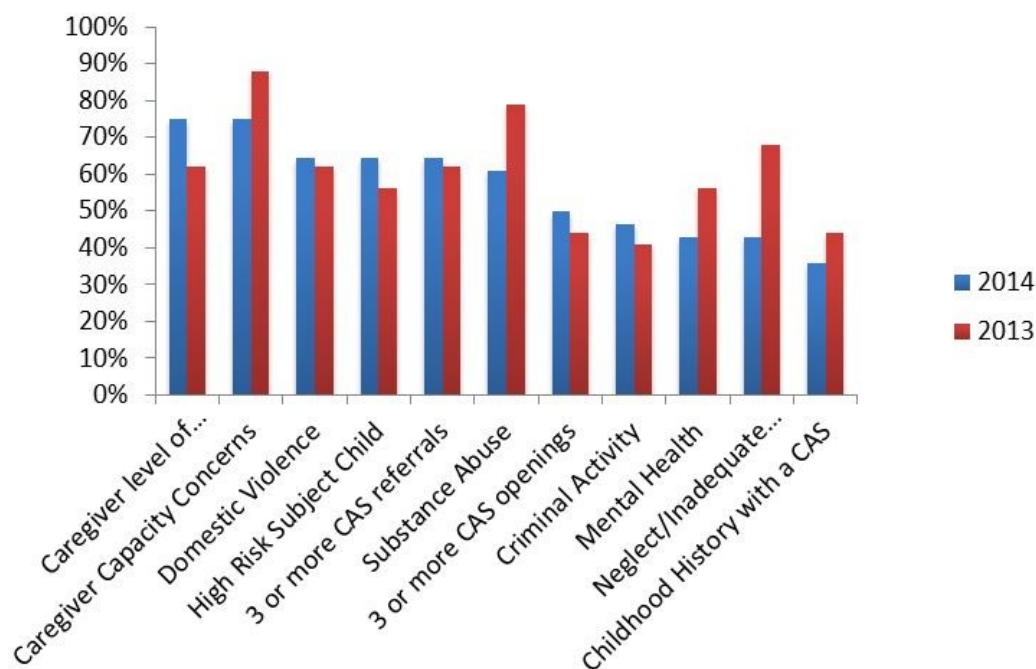
Through case reviews, the PDRC – Child Welfare collects information that, when tracked over time, may identify emerging trends. This knowledge can help contribute to understanding how services may be enhanced to better ensure the safety of children who come into contact with the child welfare system. Definitions which identify the criteria for these factors can be found in Appendix B.

In addition to the factors identified by the PDRC – Child Welfare as part of the case review process, CASs report on vulnerability factors associated with the child, youth or their family as part of their submission of the Child Fatality Case Summary Report. These vulnerability factors have similarities to the factors tracked by the PDRC – Child Welfare. Neither the vulnerability factors nor the factors that are tracked through PDRC case review are necessarily predictive of death, however; both sets of data are collected and help evaluate trends over time.

In the future, the OCC hopes to align the approach to tracking both sets of information.

The factors identified most frequently in the 2014 PDRC – Child Welfare case reviews were consistent with those identified in previous years. Chart 29 identifies the factors most frequently identified through case review in 2013 and 2014. The top five factors identified in cases reviewed by the PDRC – Child Welfare changed somewhat from 2013.

Chart 29: Top Ten Factors Identified in PDRC- Child Welfare Case Reviews



The findings continue to highlight the prevalence of multiple factors in cases reviewed by the PDRC:

- 86% (24) of the cases reviewed by the PDRC – Child Welfare in 2014 had five or more of the ten most frequently identified factors present.
- In 29% (8) of cases, all of the five most frequently identified factors were present (i.e. caregiver level of cooperation, caregiver capacity concerns, domestic violence high risk subject child and three or more CAS referrals).
- In 7% (2) of cases, all ten of the most frequently identified factors were present.
- In 14% (4) cases, nine of the top themes were identified as present.
- An additional 25% (7) cases had eight of the most frequently identified factors present.

The prevalence of these factors in cases reviewed by the PDRC – Child Welfare may warrant additional investigation to determine whether or not these factors speak to an increased risk of death.

PDRC – Child Welfare Recommendations

The PDRC – Child Welfare offers recommendations to CASs arising from review of the case materials. The recommendations are aimed at the prevention of future deaths in similar circumstances including suggestions for enhancement or change in practice and/or procedures that may inform improvement in service delivery and potentially impact child safety.

In 2014, the PDRC – Child Welfare reviewed 28 cases and issued a total of 34 recommendations. These recommendations provided by the PDRC were in addition to recommended changes identified by the involved CASs during the internal review process.

Recipients of recommendations were: 15 individual CASs, the Ministry of Children and Youth Services, the Ministry of Health and Long Term Care, the Ontario Association of Children's Aid Societies, one police service and two Regional Supervising Coroners in the Office of the Chief Coroner.

A number of similar recommendations were made in more than one case. Nine reports were accompanied by no recommendations.

Categories of Recommendations to CASs in 2014 & MCYS Response

The section below outlines the categories of recommendations most frequently made to the CASs by the PDRC – Child Welfare in 2014. Responses from the Ministry of Children and Youth Services (MCYS), which has responsibility for oversight of CASs, have been provided for each recommendation grouping.

- 1. Consider the development of practice guidelines and/or training for frontline staff regarding working with hard-to-serve or resistant families or individuals, and consider the use of Child Abuse Review Teams to provide direction and advice on service options in these cases.**

Seventy-five percent of the cases reviewed by the PDRC in 2014 had a history of challenges with the caregiver(s)' level of cooperation with the CAS, and more than 20% of the PDRC's recommendations were focused on the work of children's aid societies with "hard-to-serve" or "resistant" families.

Recommendations made by the PDRC included the importance of developing guidelines and providing training for staff on working with hard-to-serve or resistant individuals and/or families, and considerations of the use of a Child Abuse Review Team in cases where families present as resistant to intervention. In particular, the PDRC recognized the importance of incorporating the resistant nature of families into risk assessment.

MCYS Response

The mandated practice approach for delivering child protection services in Ontario, as outlined in the Child Protection Standards (CPS 2007), is based on a Differential Response Model (the DR Model) which is used in combination with the Ontario Safety Assessment in the Ontario Child Protection Tools Manual (2007) (Tools Manual) and the Ontario Child Welfare Eligibility Spectrum. The DR Model offers differential approaches to service delivery, including when working with hard to serve or resistant individuals and families, which are based on the type and severity of child maltreatment, and are customized to provide what each child and family requires. The DR model promotes a strength-based approach to service delivery and encourages engagement of the child, family and support system in decision-making and service planning. The DR model supports two approaches:

- The 'traditional' approach for cases where a criminal assault is alleged against a child and/or for extremely severe cases; and
- The 'customized' and more collaborative approach for lower risk cases.

The customized approach provides child protection workers with a more flexible range of options that will more accurately meet the unique needs of children and their families, and ensure the safety of the child. CASs have discretion to refer cases to Child Abuse Review Teams, so long as the case involves “a child who may be suffering or may have suffered abuse,” as set out in s.73 of the Child and Family Services Act.

- The ‘traditional’ approach is used when attempts to intervene via the ‘customized’ approach have proven unsuccessful and the worker is unable to engage the family in a level of cooperation that would allow the worker to determine what if any protection concerns exist. The ‘traditional’ approach is more structured and generally determined by protocols (i.e. CAS/Police protocol) whereas the ‘customized’ approach emphasizes a more flexible and individualized approach.

The ministry recently completed a review of the CPS 2007 in collaboration with the child welfare sector. The DR Model continues to be the mandated practice approach outlined in the revised Standards. It is anticipated that the revised Standards will be released in Spring 2016.

The Ontario Safety Assessment in the Tools Manual used in conjunction with the CPS 2007 provides a set of required and supplementary instruments designed to assist child protection workers in their assessment and screening of situations in which a child is alleged to be in need of protection. Safety Indicator #6 of the Ontario Safety Assessment is considered where the family refuses access to the child (e.g. intentionally coaches or coerces a child in an effort to hinder the investigation, isolating a child for extended periods of time for the purpose of avoiding investigation).

The ministry funds the Ontario Association of Children’s Aid Societies (OACAS) to provide the Education Services curricula which includes a child welfare professional training series that includes a course on engaging families. The learning objectives of this course include:

- To enhance a participant’s skill in engaging parents as collaborators in identifying goals and finding solutions;
- To understand the decision-making junctures throughout the case work process, the potential for dispute at each juncture and the ways in which a prescribed Alternative Dispute Resolution process may be successful in resolving the dispute; and
- To enhance a participant’s understanding of the Child Protection Standards that guide case planning.

The OACAS has also developed a practice note to support child welfare practitioners in obtaining all information required when determining the immediate or future risk of a child. The practice note provides information on the use of clinical engagement skills to families to help understand the reason for a client’s resistance and to gain their co-operation.

2. Improve training and practices related to safe sleep environments for infants.

Over the past five years the largest single category of deaths reviewed by the PDRC was infants in unsafe sleep environments. Consistent with 2013, approximately 10% of the recommendations made by the PDRC – Child Welfare in 2014 were directed toward CAS policies and training for staff on the risks associated with unsafe sleep practices, including bed sharing, and to enhance strategies in educating and monitoring caregivers’ provision of safe sleep environments for infants.

MCYS Response

The Ontario Safety Assessment in the Ontario Child Protection Tools Manual (2007) requires consideration of physical living conditions, including a child's sleeping arrangements when protection staff conduct a safety assessment. Safety Indicator #8 requires consideration of the living/sleeping arrangements that threaten the immediate safety of an infant such as an adult sharing a bed with an infant or an unsafe crib.

The ministry recently completed a review of the CPS 2007 in collaboration with the child welfare sector. The revised Standards will continue to require that child protection workers consider the physical living conditions, including a child's sleeping arrangements when protection staff conduct a safety assessment. It is anticipated that the revised Standards will be released in Spring 2016.

The ministry funds the Ontario Association of Children's Aid Societies (OACAS) to provide the Education Services curricula for child welfare professionals which includes a training module on Working with Infants at Risk and their Families. This module includes training on the potential risks associated with bed sharing and the necessity of appropriate sleeping environments for infants.

In 2013-14, the OACAS also developed a practice note for child welfare practitioners to assist in providing information to families, colleagues and other community professionals on safer sleeping environments for infants. The practice note provides 'Safe Sleeping Practice Tips' such as educating parents/caregivers about the significant risk of sudden infant deaths that occurs within unsafe sleep environments and potential risks associated with bed sharing.

3. Consider the assessment and treatment needs of youth in need of or in receipt of mental health intervention.

In almost 20% of the cases reviewed by the PDRC – Child Welfare in 2014, the manner of death was suicide. Approximately 10% of the PDRC – Child Welfare's recommendations related to service provision to youth struggling with mental health challenges. Areas of focus in this category of recommendations included: the importance of assessing and providing appropriate levels of service to youth in need of mental health intervention, consideration of the need for case coordination and treatment planning and the training needs of front-line staff.

MCYS Response

The Ontario government is committed to building a mental health system that delivers what children and youth need, when they need it and as close to home as possible. That is why Ontario's Mental Health and Addictions Strategy (the Strategy) was launched in 2011. The first three years of the strategy focused on children and youth. More than 50,000 additional children, youth and their families are benefitting from child and youth mental health services and supports through the Strategy.

In addition to over 770 new workers in communities, schools and courts, the Strategy has built collaborative capacity on the front lines through:

- Expanding the Tele-Mental Health Service to serve 2,800 more children, youth and families in rural, remote and under-served communities;
- Evidence-based resources and supports to school board administrators and educators to better understand and effectively support children and youth with mental health and addictions issues;
- New and expanded eating disorders treatment services, including inpatient, day treatment and outpatient programs (paediatric and adult);

- Service collaboratives established in 18 communities, bringing together service providers across sectors to deliver a coordinated system of mental health and addictions services;
- A province-wide hotline, Good2Talk, providing postsecondary students with professional counselling, information and referrals on issues of mental health, addictions and well-being; and
- A Mental Health Innovation Fund that enables partnership between postsecondary institutions, students and mental health service providers.

Building on the foundational work in the first three years of the Strategy, the *Moving on Mental Health* (MOMH) plan was launched in 2012. The plan will result in a simplified and improved experience for children and youth with mental health problems and their families so that regardless of where they live in Ontario, they will know:

- What MCYS-funded mental health services are available in their communities; and
- How to access the MCYS-funded mental health services and supports to meet their needs.

As of December 2015, the ministry has identified child and youth mental health lead agencies in 31 of 33 geographical service areas. At full implementation, lead agencies will be responsible for ensuring core community-based child and youth mental services are available in every service area and that community-based sectors work together with health care providers, schools, and other organizations so young people receive the support they need.

The core services, which will be available in all service areas as well as the minimum expectation for their delivery are defined in Program Guidelines and Requirements #01: Core Services and Key Processes. The services are:

- Targeted Prevention;
- Brief Services;
- Counselling and Therapy;
- Family Capacity Building and Support;
- Specialized Consultation and Assessments;
- Crisis Support Services; and
- Intensive Treatment Services.

Lead agencies are working with other child and youth mental health service providers as well as broader sector partners, including School Boards, Local Health Integration Networks and CASs, in order to plan for the delivery of child and youth mental health services and to develop more coherent service delivery pathways for children and youth in, through and out of care.

Building on Ontario's Mental Health and Addictions Plan, the Youth Suicide Prevention Plan, which began in 2013-14, is focused on supporting communities to enhance their local youth suicide prevention efforts so they can better respond to young people in crisis. In 2015-16, \$1.9M is being provided by the Ministry to support the Youth Suicide Prevention Plan.

In year three (i.e. 2015-16):

- 34 communities have plans in place to enhance their capacity to build awareness and mobilize collaboratively across the child and youth mental health, education and health sectors and to support the implementation of best practices to prevent death by suicide;
- Dedicated supports have been provided to First Nations, Métis, Inuit and urban Aboriginal organizations in recognition of their communities' unique cultural and organizational needs; and

- The Ontario Centre for Excellence in Child and Youth Mental Health (the Centre) is supporting *Together to Live*, a web-based toolkit that supports community mobilization. The Centre has coaching supports available to support local community groups to plan, implement and evaluate youth suicide prevention efforts. They are organizing e-forums and an in-person Aboriginal Life Promotion Forum, which took place on February 2, 2016.

4. Work with local police services to review and revise if necessary the local protocol for the investigation of child deaths.

On April 22, 2013, the Ministry of Children and Youth Services and the Office of the Chief Coroner jointly released the Addendum: Children's Aid Society and Police Protocols – Investigations of Suspicious Child Deaths in response to a recommendation provided in the 2008 Report of the Goudge Inquiry. In some cases, there continues to be an apparent lack of clarity and/or consensus in approach to the investigation of child deaths between children's aid societies and police services.

MCYS Response

The Addendum: Children's Aid Society and Police Protocols – Investigations of Suspicious Child Deaths ("Addendum") was developed in response to two recommendations from the Inquiry into Paediatric Forensic Pathology (the Goudge Inquiry), which was released on October 1, 2008. The Addendum is intended to be incorporated into existing local police/Children's Aid Society (CAS) protocols.

The ministry and the Office of the Chief Coroner (OCC) conducted an in-person training session on the Addendum in May 2013 followed by a provincial webinar in June 2013. The webinar was accessible to all CAS staff and police representatives across Ontario, which focused on sharing best practices and encouraged collaborative approaches to information sharing in cases of child deaths. The ministry and the OCC also distributed DVD copies of the webinar training to CASs and police representatives to encourage ongoing collaboration and support local CAS-police joint training.

The Addendum training is also accessible online.

The Child Protection Standards (2007) (CPS 2007) requires every CAS to have protocols with local Police Departments related to the investigation of allegations that a criminal act has been perpetrated against a child. Such protocols may include provisions concerning information sharing between the two organizations. The ministry recently completed a review of the CPS 2007 in collaboration with the child welfare sector. The revised Standards reinforce existing requirements and require that every CAS have a protocol with the society's local police department (Standard #2 Planning and Conducting a Child Protection Investigation). It is anticipated that the revised Standards will take effect in Spring 2016.

5. Improve service provision in complex cases and where patterns of multiple contacts with the Society and/or other community services are present.

Of the cases reviewed by the PDRC – Child Welfare in 2014, 64% had a history of three or more referrals to a CAS and 50% had three or more case openings. In addition, 36% of the caregivers had known involvement with a CAS during childhood. These children, youth and their families were the subjects of multiple child welfare interventions, sometimes over a period of many years.

Approximately 10% of the PDRC – Child Welfare’s recommendations in 2014 were directed toward improvement of service provision in complex cases and where patterns of multiple contacts with the Society and/or other community services are present.

The PDRC specifically identified the importance of reviewing cases where there have been multiple referrals over time, with a view to identifying opportunities to provide supports.

MCYS Response

The Child Protection Standards in Ontario (2007) (CPS 2007) require the use of the Ontario Family Risk Assessment tool during all family-based child protection investigations which identifies families whose characteristics place them at a higher likelihood of future child maltreatment than other families. In addition to the use of the Ontario Family Risk Assessment, information is gathered to determine the appropriate response and supports to promote the safety of a child. The ministry recently completed a review of the CPS 2007 in collaboration with the child welfare sector. The revised Standards address the issue of considering multiple referrals by specifying that a pattern of previous child welfare involvement is an additional factor to be considered when determining the appropriate response to a referral. It is anticipated that the revised Standards will take effect in Spring 2016.

Currently, as per Ontario Regulation 206/00 and the CPS 2007, child protection workers search all sources of information including the provincial database “FastTrack”, for information that may be relevant in determining whether or not there are reasonable grounds to believe the child or any other child in the same family is in need of protection. The Child Protection Information Network (CPIN), a single province-wide information system for all children’s aid societies (CASs), will enhance child safety by providing CASs with improved capacity to consistently track children and their outcomes, and more seamlessly access critical information including information about past referrals/reports that did not result in an investigation. The ministry will implement CPIN through a phased approach to all Ontario CASs by 2019-2020. With five CASs now live on CPIN – including the largest and second-largest CASs in the province – the records of 20% of children in care are in CPIN. An additional six agencies are actively working to implement CPIN in Spring 2016, which will represent approximately 30% of the records of children in care in the province.

6. Consider the use of case conferencing to enhance information sharing, case planning and collaboration internally and between service providers.

Case conferences and well defined policies and procedures can assist societies and involved service providers with information sharing, integration of service planning for children, youth and their families and clarity of roles and responsibilities. Case conferences and case planning should include parents and all community service providers where possible and appropriate.

Specifically, the PDRC recommended the use of case conferencing where there is divergence of opinion about case management decisions, where a Society is contemplating case closure, where a Society is contemplating returning a child to their previous caregivers and where the Society’s involvement is primarily related to a child or youth’s complex medical needs.

Where families are receiving supports from a Society related to the complex medical care of children and youth, collaborative working relationships with community health practitioners may be of benefit to support building relationships and the effective communication of medical knowledge to the family.

MCYS Response

The mandated practice approach to delivering child protection services in Ontario, as outlined in the Child Protection Standards (2007) (CPS 2007), is based on a Differential Response Model (DR Model). The DR Model encourages engagement of the child, family and their support system in decision making and case planning. The child-focused and family-centred approach to service delivery supports active and meaningful participation of families and their support system in case planning, which includes the use of case conferencing that enables the extended family, community and professionals to discuss concerns and identify strengths and seek resolutions. The CPS 2007 also emphasizes the role of CASs in facilitating communication amongst service providers.

Standard #4 – Conducting a Child Protection Investigation in the CPS 2007 outlines that one of the investigative steps during a family-based child protection investigation is to obtain releases of information and gather evidence from other professionals involved with the child/and or family (e.g. medical, law enforcement, legal, educational).

In addition, Standard #9 – Initiation of Ongoing Service, and Standard #10 – Case Management, outlines requirements to include collateral service providers in the development of the service plan and throughout the case management process whenever possible.

The ministry recently completed a review of the CPS 2007 in collaboration with the child welfare sector. The revised Standards will continue to require that child protection workers reinforce the investigative steps outlined in the CPS 2007 to gather information from other professionals involved with the child and/or family (e.g. medical, law enforcement, legal, educational) while planning and conducting a child protection investigation and during ongoing service case management. The revised Standards also include practice notes which focus on how the standards will be achieved by explaining in more detail the activities and/or concepts required by the standards and reference the use of family-centred case conferencing as a means of further promoting child safety. It is anticipated that the revised Standards will be released in Spring 2016.

Implementation Status of 2013 PDRC – Child Welfare Recommendations to CASs

The Ministry of Children and Youth Services monitors the implementation status of the PDRC – Child Welfare recommendations and the actions taken by CASs to respond to specific recommendations. MCYS reports that CASs have implemented or were in the process of implementing all of the PDRC – Child Welfare’s recommendations directed to them in 2013.

Recommendation to MCYS in 2014 & MCYS Response

- 1. Review a particular group home during the next licensing process to ensure that adequate and appropriate resources are available given the composition of children and youth placed in the home.**

The PDRC indicated that the composition of children and youth placed in the particular group home appeared to require very different treatment interventions and higher staff ratios to ensure that their safety and treatment needs are met.

MCYS Response

The group home that was the subject of this recommendation ceased operations in 2013.

Ontario is committed to improving services and supports for all children and youth, including those receiving care and treatment in residential settings. Placing agencies, such as CASs, place children and youth in residential settings that will best suit their needs. Licensees of children’s residences

are required to have an individualized plan of care in place for each child in their care in accordance with Regulations under the *Child and Family Services Act* (CFSA). This must include a plan to secure any specialized consultation, treatment and supports identified to promote the desired outcomes based on the strengths and needs of each child or youth.

Licensing staff from the Ministry of Children and Youth Services (the ministry), conduct annual licensing inspections of children's residential programs.

Child and Youth Residential Services Review

The wellbeing of children and youth in residential settings and helping them achieve positive outcomes is a key priority for the ministry. In July 2015, the ministry announced a panel of experts to undertake a review of child and youth residential services in Ontario. The panel will provide the ministry with a report and recommendations on February 29, 2016. This review builds on the work of previous reviews and reports, advising on what is needed to improve child and youth residential services.

The recommendations on how to improve the delivery of care and treatment services in residential settings will inform possible changes to the residential services system in order to optimize positive outcomes for children and youth.

Chart 30: Summary of PDRC – Child Welfare Recommendations to Other Organizations in 2014

Organization	Recommendation
Ontario Association of Children's Aid Societies	The Ontario Association of Children's Aid Societies should advocate that their member agencies establish the best practice of exploring whether individuals in receipt of child protection services provide substitute care to other children. On occasion, services are provided by children's aid societies to families who, unbeknownst to the society, provide substitute care to other children. If societies explore whether substitute care is being provided to other children in the regular course of their work with families, they may be better able to assess the appropriateness of caregiving arrangements.
Ministry of Health and Long Term Care	The ministry should consider how to improve follow-up care when at risk youth are discharged from in-patient services. Collaborative services between hospital psychiatric services and community care givers could be of benefit to the on-going care and treatment of high risk youth living in foster care or group homes who display severe risky behaviour and prevent multiple re-admissions to hospital psychiatric units.

Organization	Recommendation
Local Police Service	The local police service should review the process and approach to child death investigation to ensure consistency with protocols in place. The Policing Standards Manual (Guideline LE-027, Child Abuse and Neglect) indicates that protocols be developed with a local CAS and should address investigation requirements and procedures following the death of a child. In addition, the Manual's suggested "Framework for Model Child Abuse Protocol" includes direction on information sharing practices between police and CASs and the need to clarify the roles of both police and CASs, in the context of child death investigations. The Addendum: Children's Aid Society and Police Protocols – Investigations of Suspicious Child Deaths distributed in September 2013 also provides guidance with respect to the exchange of information between the police, child protection workers and the death investigation team during an investigation into a suspicious child death. The Addendum was prepared to allow incorporation into existing police and Children's Aid Society (CAS) information sharing protocols. Contact with the CAS to review for previous involvement of the CAS is a component of the Office of the Chief Coroner paediatric death investigation. Prompt contact with CASs after the death of a child are important, as early society knowledge about the death of a child that is receiving service from the CAS allows early opportunity for involvement of the society in the death investigation and an opportunity to provide support to the family.

Organization	Recommendation
Regional Supervising Coroner, Office of the Chief Coroner	The Regional Supervising Coroner should correspond with the local Ontario Addictions Treatment Centre (OATC) with recommendations for: a. review of their policies to support the inclusion of care by an obstetrical health care provider when methadone maintenance program patients are pregnant; and b. review of the approach of the local OATC in responding to inquiries of child welfare service providers regarding parental substance use that may impact on a caregiver's capacity. Challenges have been identified in the past between CASs and OATCs. In the case in which this recommendation arose, the OATC was not responsive to the inquiries of the Society in a timely manner. Furthermore, there was some suggestion that the local OATC may counsel parents not to disclose information about substance use which can contribute to concerns regarding high risk infants.
Regional Supervising Coroner, Office of the Chief Coroner	Regional Supervising Coroners should review the processes and approach to child death investigation with investigating coroners to ensure consistency and best practices are followed. It is important that Regional Supervising Coroners follow the identified procedures associated with child death investigation. Specifically, investigating coroners should undertake prompt record checks and notification of CASs after the death of a child, as early Society knowledge about the death of a child that is receiving service from the CAS allows early opportunity for involvement of the society in the death investigation and an opportunity to provide support to the family.

Committee Membership

Paediatric Death Review Committee (PDRC)

Dr. Dirk Huyer – Chair

Chief Coroner for Ontario

Ms. Tara McCord (past)

Coordinator (Medical)

Executive Lead, Committee Management

Office of the Chief Coroner

Ms. Kathy Kerr (current)

Coordinator (Medical)

Executive Lead, Committee Management

Office of the Chief Coroner

Ms. Karen Bridgman-Acker (past)

Coordinator (CAS)
Child Welfare Specialist
Office of the Chief Coroner

Ms. Jessica Diamond (current)

Coordinator (CAS)

Executive Lead, Child Welfare

Office of the Chief Coroner

Dr. Desmond Bohn

Provincial Medical Director-CritiCall Ontario

Ms. Susan Abell

Mr. Brad Bain

Ms. Zel Fellegi

Ms. Donna Zan

Child Welfare Consultants

Dr. Alan Hudak

Paediatrician, Orillia

Ms. Mary Ballantyne

Chief Executive Officer
Ontario Association of Children's Aid Societies

Dr. Ram Singh

Director, Paediatric Critical Care Unit
Children's Hospital
London Health Sciences Centre

Det. Avi Fagu

Det. Mike McKenzie (retired from Committee)

Det. Jakub Ostaszewski

Coroners Police Investigators

Dr. Gino Somers

Pathologist, Hospital for Sick Children, Toronto

Det. Sgt. John Braybrook (retired from Committee)

York Regional Police

Det. Sgt. Jim Kilby

York Regional Police

Dr. John Watts

Professor Emeritus, Department of Paediatrics
McMaster University Medical Centre, Hamilton

Det. Mary Vruna (retired from Committee)

Homicide Squad, Toronto Police Service

Det. Susan Gomes

Homicide Squad, Toronto Police Service

Dr. Ian Wilson

Paediatrician, Kitchener

Det. Sgt. Leon Lynch (retired from Committee)

Homicide Unit, Durham Regional Police

Dr. Burke Baird

Paediatrician, McMaster University Medical Centre

Det. Sgt. Larry Wilson

Homicide Bureau, York Regional Police

Dr. Alejandro Floh

Critical Care, Hospital for Sick Children, Toronto

Det. Sgt. Deb Gillis (retired from Committee)

Major Crime, Crime Investigations Unit

Peterborough Lakefield Police

Det. Sgt. Lynne Buehler

Investigative Services

Peterborough Lakefield Police

Ms. Yasmin Nowsherwanji

Ms. Ramona Bhagwandin

Administrative Coordinators,

Office of the Chief Coroner

Deaths Under Five Committee (DU5C)

Dr. Dirk Huyer – Chair

Chief Coroner for Ontario

Ms. Tara McCord (past)

Coordinator (Medical)

Executive Lead, Committee Management

Office of the Chief Coroner

Ms. Kathy Kerr (current)

Executive Lead, Committee Management

Office of the Chief Coroner

Ms. Jessica Diamond (current)

Coordinator (CAS)

Executive Lead, Child Welfare

Office of the Chief Coroner

Det. Mary Vruna

Homicide Squad, Toronto Police Service

Det. Susan Gomes

Homicide Squad, Toronto Police Service

Dr. David Chiasson

Forensic Pathologist
Hospital for Sick Children, Toronto

Dr. Charis Kepron

Forensic Pathologist
Eastern Ontario Regional Forensic Pathology Unit, Ottawa

Det. Avi Fagu

Det. Mike McKenzie

Office of the Chief Coroners Investigators

Dr. Chitra Rao

Regional Forensic Pathology Unit
Hamilton, Ontario

Det. Sgt. J. J. Allan

Homicide Unit, Durham Regional Police

Det. Sgt Mitch Martin

Homicide Unit, Durham Regional Police

Dr. Mike Shkrum

Head, Regional Forensic Pathology Unit, Southwestern Ontario
London, Ontario

Dr. Michelle Shouldice

Paediatrician
Suspected Child Abuse and Neglect Program
Hospital for Sick Children, Toronto

Det. Insp. Paul McCrickard

Ontario Provincial Police
Criminal Investigations Bureau

Dr. Jayantha Herath

Forensic Pathologist
Provincial Forensic Pathology Unit, Toronto

Det. Marc-Andre Guy

Ottawa Police Service

Ms. Yasmin Nowsherwanji

Ms. Ramona Bhagwandin

Administrative Coordinators,
Office of the Chief Coroner

Staff Sgt. Todd LaMarre

Windsor Police Service

Det. Cst. Brian Welsh

Guelph Police Services

Det. Peter Thom

Hamilton Police Service

Staff Sgt. Vicki MacDonald

Waterloo Police Service

Det. Sgt. Peter Trimble

Toronto Police Service – Homicide

Det. Sgt. John Braybrook

York Regional Police

Staff Sgt. Rhonda Corsi

York Regional Police

Ms. Brenda Marsillo

Product Safety Officer

Consumer Product Safety, Health Canada

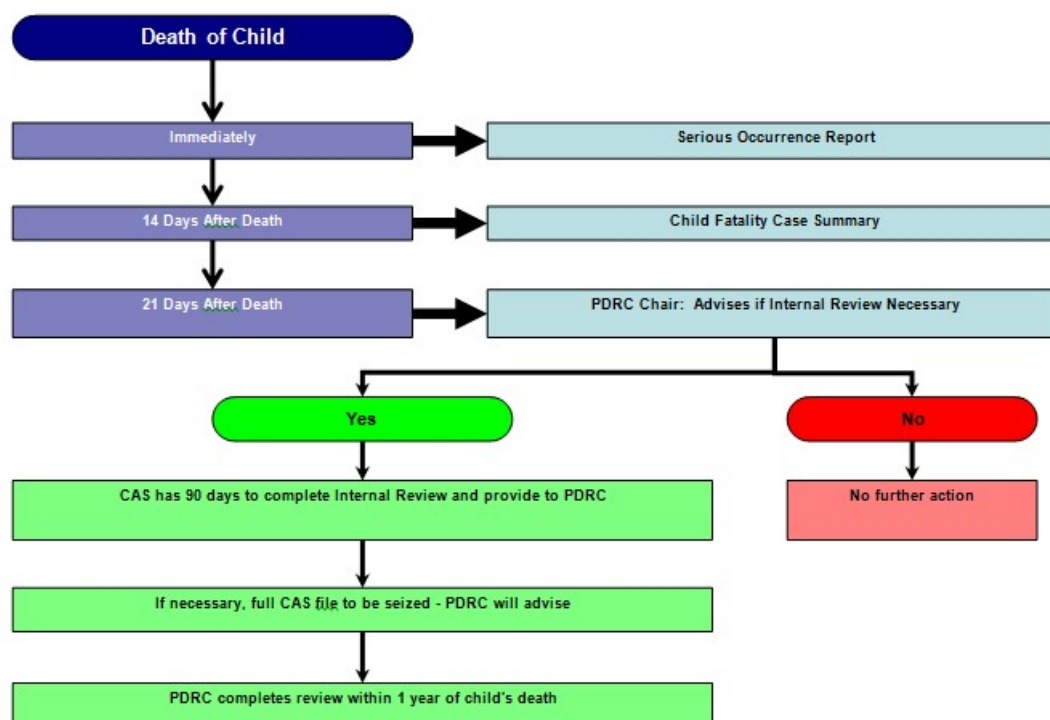
Ms. Mary Ellen Hurman

Crown Attorney

Ministry of the Attorney General, Toronto

Appendix A – Joint Directive on Child Death Reporting and Review

Chart 32 shows the process and timelines arising from the 2006 Joint Directive between the OCC and MCYS for Child Death Reporting and Review.



CAS Internal Child Death Reviews

When is an internal child death review requested?

The Chair of the PDRC reviews the CAS Child Fatality Case Summary Report and the Coroner's Investigation Statement (CIS) and considers the following criteria when deciding if a CAS will be requested to conduct and forward an Internal Review to the PDRC:

- Meets the criteria of the 2006 Joint Directive (CAS involvement within 12 months of the death)
- When a child dies as a result of questionable circumstances; and
- Where the circumstances surrounding the child's death may relate in any way to the reasons for service and/or CAS involvement.

Why is an internal child death review requested?

An internal child death review is requested by the Chair of the PDRC for the purposes of conducting an analysis of the context within which the death occurred. Internal child death reviews provide an opportunity for individual CASs, and the child welfare sector as a whole, to learn from child deaths with a view to identifying areas of potential improvements to CAS policies, practices and procedures.

Who completes the CAS internal child death review?

When the Chair of the PDRC requests that a CAS undertake an internal child death review, the CAS is required to establish a review team which must include an independent external reviewer with appropriate clinical expertise to participate in the review.

Levels of PDRC – Child Welfare Reviews

There are three levels of PDRC – Child Welfare review:

Executive Review: These cases which upon review by the Executive Committee of the PDRC, it is determined that no further review by the CAS or PDRC – Child Welfare is required, as the circumstances surrounding the child's death do not relate to the reasons for services and/or CAS involvement. For example, cases where the child's family had no CAS involvement until the injury leading to the death, or the child was known to CAS, but the death was natural and not unexpected, or the child died as the result of an incident unrelated to the reasons for the family's involvement with CAS.

Pending DU5C/further investigation: On occasion, the decision to request an internal child death review from a CAS is postponed pending the completion of the Coroner's investigation and/or review by the DU5C, to await additional information and context regarding the child's death.

Internal and PDRC Review: If the PDRC – Child Welfare requests an internal child death review, CASs are requested to submit their report within 90 days, and the PDRC – Child Welfare has up to 12 months to review the case and issue a report that may contain further recommendations. All cases in which an internal child death review has been completed are reviewed by at least two members of the PDRC – Child Welfare – one police representative and one child welfare representative – review the following case material for each death with CAS involvement: the Serious Occurrence Report, Child Fatality Case Summary Report, the Internal Child Death Review, police report, Coroner's Investigation Statement, Report of Post Mortem Examination, toxicology reports (if applicable) and any other investigative reports provided (e.g. report from the Office of the Fire Marshal). After discussion at a committee meeting, a final case report is prepared consisting of a summary of events, discussion and recommendations (if any), with a goal to

inform the prevention of future deaths in similar circumstances. The report is forwarded to the involved CAS, MCYS and the referring Regional Supervising Coroner who may conduct further investigation (if indicated).

Recommendations are also distributed by the Committee Chair to agencies and organizations who may be in a position to effect implementation. Organizations are asked to respond back within one year with the status of implementation of recommendations.

CAS Response to PDRC – Child Welfare and Internal Review Recommendations

Following receipt of PDRC – Child Welfare reports, individual CAS agencies consider the report and implement recommendations as appropriate. Progress reports are submitted to MCYS Regional Offices outlining agency responses to the recommendations addressed to them. Ministry Regional Offices are responsible for follow-up with individual agencies on a quarterly basis regarding the actions taken to respond to the Internal Review and PDRC recommendations.

Findings and recommendations from these reviews have been utilized to change practices, develop training, policy and procedures and to initiate new approaches and programs.

Appendix B - PDRC – Child Welfare Case Review Themes - Definitions

Substance Abuse: CAS documented that at least one of the caregivers suffered from substance abuse issues.

Mental Health: CAS documented that at least one of the caregivers suffered from mental health issues.

Domestic Violence: CAS documented that the caregiver(s) had been involved in at least one partner violence incident.

Criminal Activity: CAS and/or PDRC have information that the caregiver (s) has a history of criminal activity.

Physical Abuse: It was suspected and/or verified by a CAS on at least one occasion, that the child/children in the family were victims of physical abuse.

Emotional Abuse: It was suspected and/or verified by a CAS on at least one occasion, that the child/children in the family were victims of emotional abuse.

Sexual Abuse: CAS documented history of sexual abuse within the family (caregivers were victims or perpetrators) and/or the CAS has suspected and/or verified on at least one occasion that the child/children in the family were victims of sexual abuse and/or perpetrators.

Neglect/Inadequate Supervision: It was suspected and/or verified by a CAS on at least one occasion, that the child/children in the family were victims of neglect or inadequate supervision.

3 or more CAS Openings: A CAS had opened a file relating to the caregiver(s) on at least three separate occasions.

3 or more CAS Referrals: A CAS had received at least three separate referrals relating to the caregiver(s) (referrals could have been received during one opening, or during a number of openings or could have been reports received, not investigated).

Previous Death of a Child: The caregiver(s) have experienced a previous death of a child.

Caregiver Capacity Concerns: CAS or PDRC has noted concerns about the caregiver(s) parenting capacity either before or after the death of the child.

Childhood History with CAS: One or both of the caregivers has had involvement with the CAS as a child.

Youth of Primary Caregiver: The primary caregiver is 24 years old or younger

High Risk Subject Child: The deceased child was "high risk" meaning < 1 year of age; and/or had special needs

Unsafe/hazardous Living Conditions: Home environment may have placed a child at risk of harm and/or contributed to the death of the child (very cluttered, dirty, dangerous)

Problems with caregivers' level of motivation or cooperation with intervention: Pattern of avoidance, lack of follow through, aggressive and/or unmotivated to cooperate.

Contacts

Dr. Dirk Huyer

Chair

Chief Coroner for Ontario

Phone: 647-329-1814

Ms. Jessica Diamond

Executive Lead, Child Welfare

Paediatric Death Review Coordinator — CAS

Phone: 647-329-1835

Ms. Kathy Kerr

Executive Lead, Committee Management

DU5C Coordinator

Paediatric Death Review Coordinator – Medical

Phone: 647-329-1843

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[1] Kinney, HC, Thach BT. The sudden infant death syndrome. N Engl J Med 2009; 361 (8): 795-805.

[2] With the exception of Akwesasne Child and Family Services, which is governed by the Mohawk Council of Akwesasne.

[3] Fisher's exact test was performed, $p = 0.57$.

[4] Chi-square test was performed. Relation between the variables was significant, $\chi^2(4, N=356) = 35.99, p < 0.0001$.

[5] Chi-square test was performed. Relation between the variables was significant, $\chi^2(3, N=1028) = 66.73, p < 0.0001$.

[6] The Northern and Rural Healthcare Panel (2011, March 30). *Rural and Northern Healthcare Report Executive Summary*. Retrieved from http://www.health.gov.on.ca/en/public/programs/ruralnorthern/docs/exec_s...

[7] A chi-square test was performed. Relation between the variables was significant, $\chi^2 (4, N=356) = 74.991, p < 0.0001$.

[8] A chi-square test was performed. The relation between the variables was extremely statistically significant, $\chi^2 (1, N=356) = 28.673, p < 0.0001$.

[9] A chi-square test was performed. The relation between the variables was not statistically significant, $\chi^2 (4, N=382) = 3.703, p < 0.448$.

[10] A Fisher's exact test was performed. The relation between the variables was not significant, $p = 0.5149$.

[11] Five of these cases were reviewed in the 2014 calendar year. The remainder were reviewed in the 2015 calendar year and the results of those reviews will be detailed in the next Annual Report.
