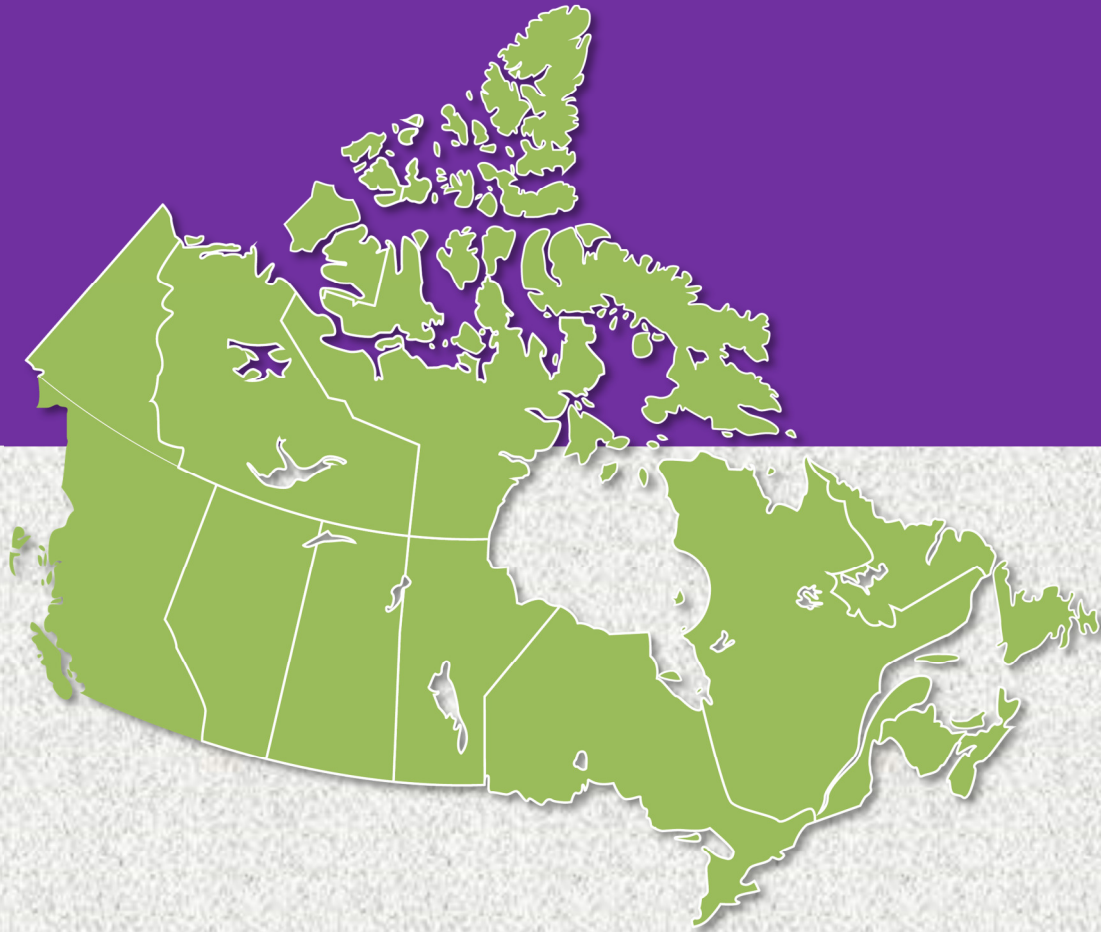


# Child Death Review in Canada: A National Scan



*Report prepared by the*

saskatchewan

**preventioninstitute**

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MAY 2016

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## 1. Introduction

In 2013, the Canadian Paediatric Society (CPS) released a position statement highlighting the importance of legislated, structured child death review (CDR)<sup>2</sup> across Canada (Ornstein, Bowes, Shouldice, Yanchar, & Canadian Paediatric Society, 2013). According to the CPS, formal CDR processes are designed “to advance understanding of how and why children die, to improve child health and safety, and to prevent injuries and death in the future” (p. 1). Effective CDR processes bring people from multiple disciplines together in order to comprehensively discuss the circumstances around the death of a child through a broad, ecological perspective (Covington, Foster, & Rich, 2005; Fraser, Sidebotham, Frederick, Covington, & Mitchell, 2014). Importantly, such CDR processes also produce recommendations aimed at the development of preventive measures and/or the improvement of systems and policies.

Currently, Saskatchewan does not have a formal, provincial CDR process. Instead, multiple agencies and organizations conduct child death reviews and investigations as specified in their individual mandates (e.g., Office of the Chief Coroner, Advocate for Children and Youth, Ministry of Social Services, Ministry of Justice). In contrast to Saskatchewan’s current situation, the CPS recommends that “a comprehensive, structured and effective CDR program be initiated for every region in Canada, with systematic reporting and analysis of all child and youth deaths and the ability to evaluate the impact of case-specific recommendations” (Ornstein et al., 2013; p. 4). It is expected that such a system would lead to better recognition of trends and highlight risks or systemic issues that may be modified to reduce the number of child deaths. Although the current arrangement in Saskatchewan allows for the review of specific subsets of child deaths, a coordinated provincial process would facilitate the development of prevention efforts for all Saskatchewan children.

Coordinated CDR processes can lead to the identification of small but important trends and allow for the possibility of aggregate reviews, both of which can have a significant impact on prevention efforts (Vincent, 2014). A number of positive outcomes from coordinated, multidisciplinary CDR processes have been reported in other countries: improved information collection and reporting in relation to child deaths; the identification of modifiable factors contributing to deaths; increased public awareness of these factors; local actions at the level of organizations and communities (e.g., prevention initiatives and changes in practice); and changes in legislation (Fraser et al., 2014). A coordinated provincial process would likely provide similar benefits in Saskatchewan, and increase the ability of multiple stakeholders to work toward reducing the number of child deaths in Saskatchewan.

There has been interest in creating a provincial CDR process for many years in Saskatchewan, and exploratory work in this area has occurred in the past. The work completed in the past had not progressed past this exploratory phase. In recognition of the continued importance of CDR in Saskatchewan, a provincial advisory committee was created to discuss the potential for a provincial

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<sup>2</sup> This acronym is used to represent death reviews of children and youth aged 19 and younger.

CDR process. This committee includes representation from the Office of the Chief Coroner, the Ministry of Justice, the Ministry of Social Services, the Advocate for Children and Youth, Department of Pediatrics, the Saskatchewan Association of Chiefs of Police, the Regina and Saskatoon Police Services, Saskatchewan Government Insurance (SGI), and the Saskatchewan Prevention Institute, along with several Medical Health Officers from around Saskatchewan. At the introductory meeting held in September 2015, it was decided that one of the initial steps should be to learn about CDR processes in the rest of Canada. The following report completed by the Saskatchewan Prevention Institute summarizes the information that was gathered from each of the provinces and territories.

## 2. Method

In January and February 2016, the Saskatchewan Prevention Institute conducted a brief Internet search to gather initial information about CDR processes across Canada and to identify potential contacts for telephone interviews. Telephone interviews were then conducted with people involved in CDR in each of the provinces and territories in Canada. The purpose of these interviews was to gather information about their current CDR processes to inform the Saskatchewan CDR Advisory Committee and their discussions around instituting a universal CDR process in Saskatchewan. Therefore, particular attention was paid to provinces and territories that identified a multidisciplinary provincial CDR process. The initial list of contacts included Chief Coroners and Chief Medical Examiners, Chairs and Executive Leads of provincial CDR committees, staff from Children's Advocates' Offices, and staff from Child and Family Services. When additional people were identified through the initial phase of interviews, they were contacted as well. Although efforts were made to interview key contacts involved in CDR in each province and territory, it is important to acknowledge that there may be others involved in CDR who were not interviewed.

Participants were asked to describe the nature and extent of their CDR process, along with their mandate, who is involved, resource requirements, who they share information with, and the benefits and challenges experienced in their process. Importantly, many of the participants also shared recommendations and advice for others initiating a CDR process. The full interview schedule can be found in Appendix A.

### 3. National Findings

The following tables summarize the results of these interviews. Table 1 provides information about the types of deaths reviewed or investigated<sup>3</sup> in each province and territory and whether a coordinated provincial process is in place. As this table shows, six provinces currently have provincial CDR processes, while three additional provinces/territories are currently exploring the possibility of instituting such a process. Table 2 provides more specific information for the provinces that identified a provincial multidisciplinary CDR process.

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<sup>3</sup> It is important to note that there is a distinction between a “review” and an “investigation”, particularly for coroners and medical examiners. Coroners and medical examiners investigate deaths covered under their provincial and territorial Acts, with the goal of determining the cause and manner of death. Reviews often examine the larger picture, including organizations, systems, policies, and processes. Although different agencies may use the terms “review” and “investigate” differently, coroners and medical examiners conduct investigations, with the aforementioned goal.

**Table 1. Child death review across Canada by province/territory**

| Province/Territory | Types of child deaths reviewed  | Responsibility for review   | Universal multidisciplinary process   | Plans for changing death review process   |
|--------------------|---|---|---|---|
| <b>Alberta</b>     | <p>1) Deaths that fall under their <i>Fatality Inquiries Act</i><sup>4</sup>.</p> <p>2) All deaths of children currently receiving designated services from the Ministry of Human Services or within 2 years of file closure are examined. Also examine all deaths of children receiving services in the youth justice system (open or closed custody). An investigation is conducted if a systemic issue is identified or if the Advocate decides one is warranted.<sup>5</sup></p> <p>3) Deaths of children who die in hospital, were transferred to another hospital, or were recently associated with a hospital.</p> | <p>1) Office of the Chief Medical Examiner. There is also a Fatality Review Board, who recommends cases for a public fatality inquiry (all deaths of children in care must be considered for inquiry unless the Board is satisfied that the death was due to natural causes).</p> <p>2) Office of the Child and Youth Advocate, Ministry of Human Services, and the Council for Quality Assurance (also within the Ministry of Human Services). These three processes are distinct from one another.</p> <p>3) Hospitals do their own internal mortality reviews.</p> | <p><b>No</b><br/>There was an informal universal CDR committee that was temporarily suspended in 2013. A universal process has not yet been reinstated.</p> | <p>CDR working group based within the Ministry of Health is working towards establishing a universal process.</p> <p>Discussions have begun with other relevant ministries.</p> |

<sup>4</sup> See Appendix B for a complete list of deaths that are covered under the provincial and territorial Acts.

<sup>5</sup> See Appendix C for a complete list of processes for child deaths as stipulated by the provincial and territorial Child and Youth Advocate Acts.



| Province/Territory          | Types of child deaths reviewed  | Responsibility for review  | Universal multidisciplinary process   | Plans for changing death review process  |
|-----------------------------|---|--|---|--|
| <b>Alberta</b><br>continued | 4) All perinatal deaths.  | 4) Separate perinatal death review process.  |   |  |
| <b>British Columbia</b>     | <p>1) All deaths of children under 19 are reported to the BC Coroners Service. The Child Death Review Unit (CDRU) is mandated under the <i>Coroners Act</i>.</p> <p>2) All deaths of children who were receiving, or whose family was receiving, a reviewable service at the time of their death or in the year prior to their death as stipulated in the <i>Representative for Children and Youth Act</i><sup>6</sup>.</p> | <p>1) CDRU and standing review panel.</p> <p>2) Representative for Children and Youth.</p> | <p><b>Yes</b><br/>Since 2003. CDR process was changed in 2012, and the Standing Death Review Panel was established in 2013.</p> <p>Panels review aggregate data from a number of years focused on a particular topic.</p> | <p>1) May reduce the number of panels from 3 to 2 per year due to the number of topics already covered.</p> <p>Data collection protocols are currently being revised.</p> <p>Plan to do more work around monitoring compliance with their recommendations.</p> |

<sup>6</sup> See Appendix C.

| Province/Territory | Types of child deaths reviewed  | Responsibility for review   | Universal multidisciplinary process | Plans for changing death review process   |
|--------------------|---|---|-------------------------------------|---|
| <b>Manitoba</b>    | <p>1) All deaths of children born alive after 20 weeks of gestation and before their 18<sup>th</sup> birthday are reportable to the Office of the Chief Medical Examiner (CME), irrespective of cause and manner of death (stipulated by their <i>Fatality Inquiries Act</i>). All unnatural deaths must be investigated.</p> <p>2) All deaths of children between the ages of 1 day and 18 years.</p> <p>3) All children who have received reviewable services from the Ministry of Family Services within a year of death, as stipulated by the <i>Child and Family Services Act</i><sup>7</sup>. Reviewable services include child welfare, mental health, addictions, youth justice, and young adults who are under an extension of care.</p> | <p>1) Office of the Chief Medical Examiner prepares a monthly summary of all child deaths.</p> <p>All unnatural and preventable natural deaths are forwarded to the Children’s Inquest Review Committee (CIRC).</p> <p>2) College of Physicians and Surgeons of Manitoba has two separate committees (Maternal and Perinatal Health Standards Committee and Child Health Standards Committee), consisting solely of College physicians.</p> <p>3) Office of the Children’s Advocate. Also have an interdisciplinary Advisory Committee that includes people from medical, social work, legal, and mental health fields.</p> | <b>Yes</b>                          | <p>3) Currently tabled legislation would result in a number of changes (e.g., would become responsible for monitoring compliance with recommendations and would begin to investigate serious injuries as well as deaths).</p> |

<sup>7</sup> Manitoba, Child and Family Services Act: <https://web2.gov.mb.ca/laws/statutes/ccsm/c080e.php>

| Province/Territory               | Types of child deaths reviewed  | Responsibility for review  | Universal multidisciplinary process  | Plans for changing death review process   |
|----------------------------------|---|--|--|---|
| <b>New Brunswick</b>             | Deaths that fall under their <i>Coroners Act</i> .  | Coroner Services.<br><br>The Child Death Review Committee reviews sudden and unexpected deaths of children under the age of 19 that are reported to the coroner. | <b>Yes</b><br>Since 2009.<br><br>Previously only reviewed the deaths of children receiving services from the Ministry of Social Development. | Plan to do a 10 year retrospective review to look at statistics and trends, as well as previous recommendations. Will be updated annually.<br><br>Currently exploring whether to review natural deaths that are not reported to Coroner Services. |
| <b>Newfoundland and Labrador</b> | Deaths of children under the age of 19 that fall under their <i>Fatalities Investigations Act</i> . | Office of the Chief Medical Examiner.<br><br>Child Death Review Committee.<br><br>The Advocate for Children and Youth can also do a separate review of any case. | <b>Yes</b><br>Since 2014.  | Plan to assess their process regularly, and make changes as needed.   |

| Province/Territory           | Types of child deaths reviewed   | Responsibility for review  | Universal multidisciplinary process | Plans for changing death review process  |
|------------------------------|--|--|-------------------------------------|--|
| <b>Northwest Territories</b> | <p>Deaths that fall under their <i>Coroners Act</i>.</p> <p>Additional information is collected for deaths of children under 2 (Infant Death Investigation Form), including re-enactments within 2 days.</p>   | Coroner's Service of the Northwest Territories   | <b>No</b>                           | <p>Interest and discussions around establishing a formal, standardized review and reporting system.</p> <p>Updating their legislation so that Child and Family Services have to report any child death to the Coroner's Service.</p>                                   |
| <b>Nova Scotia</b>           | <p>1) Deaths that fall under their <i>Fatality Investigations Act</i>.</p> <p>2) Children receiving child welfare services.</p> <p>3) Death of a child receiving government services. A complaint can be initiated by an individual or under the Ombudsman's own motion, if deemed to be in the public's interest.</p> | <p>1) Medical Examiner Service.</p> <p>2) Department of Community Services (internal review).</p> <p>3) Office of the Ombudsman.</p> | <b>No</b>                           | <p>1) According to the Chief Medical Examiner, no current plans to institute a CDR process, despite interest from pediatricians and others.</p> <p>3) Recommended the establishment of a provincial inter-agency CDR team in their 2014 Child Death Review report.</p> |

| Province/Territory          | Types of child deaths reviewed  | Responsibility for review  | Universal multidisciplinary process   | Plans for changing death review process  |
|-----------------------------|---|--|---|--|
| <b>Nunavut</b>              | Deaths that fall under their <i>Coroners Act</i> .  | Office of the Chief Coroner.   | <b>No</b>   | Planning on instituting a CDR process in the near future. In the process of gathering information from other jurisdictions.  |
| <b>Ontario</b>              | Deaths that fall under their <i>Coroners Act</i> , including all deaths of children under 5 years of age, as well as all deaths of children under 19 years of age with involvement of a Children's Aid Society within 12 months of their death. | Office of the Chief Coroner with the Deaths Under 5 Committee, the Paediatric Death Review Committee – Medical, and the Paediatric Death Review Committee – Child Welfare. | <b>Yes</b><br>Reviews are two-tiered: Executive Team Review and/or Full Committee Review. | Reworking their system from one focused on a subset of individual cases to one that is able to utilize aggregate data of all child deaths for prevention-focused work. |
| <b>Prince Edward Island</b> | Deaths that fall under their <i>Coroners Act</i> .  | Coroners Service.  | <b>No</b>   | Not at this time.  |
| <b>Quebec</b>               | Deaths that fall under their <i>Coroners Act</i> .  | Office of the Chief Coroner.<br><br>All child deaths that are not deemed to be of natural causes are eventually reviewed by a CDR committee.                               | <b>Yes</b><br>This is currently not a formal committee.                                   | A formal written mandate is being developed as well as a formal structure (which does not currently exist).  |

| Province/Territory | Types of child deaths reviewed  | Responsibility for review   | Universal multidisciplinary process | Plans for changing death review process  |
|--------------------|---|---|-------------------------------------|--|
| Saskatchewan       | <p>1) Deaths that fall under their <i>Coroners Act</i> including all sudden, unexpected and unnatural deaths (any age); all deaths in a custody facility as defined by <i>The Youth Justice Administration Act</i><sup>8</sup>; deaths of any resident of a foster home, group home, or place of safety within the meaning of <i>The Child and Family Services Act</i><sup>9</sup>; or any minor while under the care, custody, or supervision of the Ministry of Social Services.</p> <p>2) Deaths of children receiving services from the Ministry of Social Services at the time of their death or within 12 months prior to their death, including children from any of the 17 First Nations agencies in the province who provide equitable child and family services under the <i>Child and Family Services Act</i>.</p> | <p>1) Office of the Chief Coroner.</p> <p>2) Ministry of Social Services (internal process, but reports are provided to the Advocate for Children and Youth). Two tiered process, where deaths that may have been impacted by their services undergo a comprehensive review rather than a cursory review.</p> | No                                  | <p>2) Currently working on establishing a more collaborative information sharing agreement with the Ministry of Health.</p> <p>Currently working on an improved system for tracking recommendations.</p> |

<sup>8</sup> Saskatchewan, Youth Justice Administration Act: <http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/Y2.pdf>

<sup>9</sup> Saskatchewan, Child and Family Services Act: <http://www.qp.gov.sk.ca/documents/english/statutes/statutes/C7-2.PDF>

| Province/Territory                       | Types of child deaths reviewed  | Responsibility for review   | Universal multidisciplinary process | Plans for changing death review process  |
|--|---|---|-------------------------------------|--|
| <p><b>Saskatchewan</b><br/>continued</p> | <p>3) Deaths of children receiving services from the Ministry of Social Services at the time of their death or within 12 months prior to their death, as well as deaths of children receiving services from the Ministry of Justice, Corrections and Policing Division at the time of their death or within 30 days prior to their death.</p> <p>4) Deaths of children where there is a suspicion or evidence of a Category 1 or 2 Communicable Disease<sup>10</sup> in the Saskatchewan Disease Control Regulations.</p> <p>5) Deaths of inpatient children under the care of a pediatrician. Child deaths that occur in the community are not reviewed unless requested by a pediatrician involved in the outpatient management of the child.</p> | <p>3) Advocate for Children and Youth (includes the Advocate, the Program Manager of Investigations, investigators, and administrative support).</p> <p>4) Medical Health Officers, with subsequent reporting to the Chief Medical Health Officer, the Northern Inter-Tribal Health Authority, and the First Nations and Inuit Health Branch (FNIHB). FNIHB may review such deaths if they are of First Nations children who live on reserve.</p> <p>5) Pediatric Mortality and Morbidity Meeting Committee, Regina Qu'Appelle Health Region.</p> |                                     | <p>5) Plan to expand committee to a multidisciplinary team in Spring 2016.</p> |

<sup>10</sup> A list of Category 1 and 2 reportable diseases can be found at <http://www.ehealthsask.ca/services/manuals/Documents/AppendixA.pdf>

| Province/Territory                             | Types of child deaths reviewed   | Responsibility for review   | Universal multidisciplinary process | Plans for changing death review process                            |
|--|--|---|-------------------------------------|--|
| <b>Saskatchewan</b><br>continued <sup>11</sup> | 6) Deaths of children that occur at Royal University Hospital. May review the deaths of children from other jurisdictions, if invited. | 6) Royal University Hospital Department of Pediatrics.  |                                     |  |
| <b>Yukon</b>                                   | Deaths that fall under their <i>Coroners Act</i> . Inquests can be ordered for children who die in care.                               | Coroner's Service.<br><br>Ontario's CDR committees may assist with cases that require further review. | <b>No</b>                           | Not at this time because the number of child deaths is very small. |

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<sup>11</sup> Deaths of children that occur while the child is receiving services from Ministry of Justice, Corrections and Policing Division are subject to an internal review. Deaths of children that occur during a domestic violence situation will be reviewed by Saskatchewan's domestic violence death review panel. This panel will begin operating in June 2016. At the time of this report, no further information could be obtained about either of these review processes.



**Table 2. Structure and features of provincial child death review committees in Canada**

| Province/<br>Territory      | Core team<br>members   | Process   | Age range and<br># of cases<br>reviewed<br>annually   | Sources of data  | Resources  | Outputs  |
|-----------------------------|--|---|---|--|--|--|
| <b>British<br/>Columbia</b> | <p>Housed by the Coroners Service, under the Ministry of Public Safety and Solicitor General.</p> <p>Child death review unit (CDRU) consists of the Chair, a CDR coroner, a child death coroner, and a .5 researcher.</p> <p>The standing panel is comprised of government, academic, and topic experts (Public Health, medicine, psychiatry, child welfare, child advocacy, law enforcement, medicine, Aboriginal health, injury prevention).</p> | <p>There are three types of reviews:</p> <ol style="list-style-type: none"> <li>1) new deaths are reviewed daily to look for trends and anything that may require immediate attention;</li> <li>2) an annual aggregate review; and</li> <li>3) panel reviews convened around a specific topic (e.g., drowning), where aggregate data from a number of years is reviewed. Panels are typically convened 3 times a year.</li> </ol> | <p>All deaths of children under the age of 19 years.</p> <p>Approximately 765 cases are reviewed annually. Of these, 300 are reviewed for statistical information (e.g., age, sex, geographic location, cause of death); 300 are reviewed for quality assurance purposes; 165 undergo panel review.</p> | <p>Information recorded by the coroner.</p> <p>For panel review, the CDRU will aggregate between 5 and 10 years of individual case files related to the topic. The academic and research literature, provincial data sources, and national and international data are also examined. Panel members and topic experts also share their knowledge and expertise.</p> | <p>Annual budget of approximately \$300,000.</p> <p>CDRU provides all of the support to the panels. Participation is voluntary, and members are not paid for their time. Travel expenses can be paid if not covered by their own agency.</p> | <p>Recommendations from the panels are brought forward to the Chief Coroner, who forwards the recommendations to the identified agencies and then releases these recommendations publicly in a report.</p> <p>Annual aggregate reports are also released publicly.</p> |

| Province/<br>Territory | Core team<br>members   | Process  | Age range and<br># of cases<br>reviewed<br>annually   | Sources of data   | Resources   | Outputs   |
|------------------------|--|--|---|---|---|---|
| <b>Manitoba</b>        | <p>Housed by the Office of the Chief Medical Examiner (CME), under the Ministry of Justice.</p> <p>Children’s Inquest Review Committee (CIRC) members include the Chair (CME), a crown attorney, Child and Family Services, pediatricians (including one from Child Protection Services), a pediatric pathologist, police and RCMP, the Children’s Advocate, and a representative of the Association of Manitoba Chiefs.</p> | <p>The CME prepares a summary of all child deaths on a monthly basis and provides it to the Child Health Standards Committee for their deliberations. All unnatural and preventable natural deaths are forwarded to the CIRC. This committee meets the first Friday of the third month after the child dies.</p> | <p>All deaths of children born alive after 20 weeks of gestation and before their 18<sup>th</sup> birthday.</p> <p>Approximately 175 cases are reviewed annually.</p> | <p>Usual sources include medical charts, Child and Family Services records, school records, prison records, and any other records that pertain to the deceased child. The Office of the CME can access any information pertinent to the death of the child.</p> | <p>No separate budget for CDR. All costs are covered under the global budget.</p> <p>Members of the CIRC are not paid and their expenses are not covered. Members’ organizations cover the costs.</p> | <p>The CIRC advises the CME to take appropriate action to prevent similar deaths either by calling an inquest or making recommendations to the appropriate departments and/or agencies.</p> <p>Annual reports are prepared and are available to the public.</p> |

| Province/<br>Territory      | Core team<br>members  | Process  | Age range and<br># of cases<br>reviewed<br>annually   | Sources of data   | Resources   | Outputs  |
|-----------------------------|---|--|---|---|---|--|
| <p><b>New Brunswick</b></p> | <p>Housed in the Coroner Services Branch, under the Department of Public Safety.</p> <p>Core members include a police officer, a pediatrician, a university social work professor, a First Nations representative, a lawyer, and a representative from the Coroner Services Branch. It is mandated that their Chair is a coroner - the Deputy Chief Coroner takes this role. May soon include a forensic pathologist.</p> <p>Ad hoc participants as needed.</p> | <p>Chief Coroner identifies cases of child death. Files are uploaded to a secure system and the CDR Chair decides whether cases will be reviewed (natural deaths are not typically reviewed). Case information goes to committee members, and they meet once a month to review any active files. The Chair assigns cases to group members to take the lead on presenting. They review the case (can take multiple sessions) and come up with findings and recommendations.</p> | <p>All deaths of children under the age of 19.</p> <p>Approximately 7 or 8 cases are reviewed annually.</p> <p>Over the past 5 years, they have reviewed a low of 5 and a high of 9 cases annually.</p> | <p>Coroner’s file (all post-mortem analyses, police report, school and health records, etc.)</p> <p>If the child is in care, the Ministry of Social Development provides their internal report within 30 days.</p> <p>The Committee does not have investigative ability other than to call witnesses. The coroner gets all relevant information for them.</p> | <p>Costs are minimal and are covered by the operating costs of the Coroner Services Branch, including administrative support.</p> <p>Members may be paid as part of their job or volunteer. Meal/travel costs to get to meetings are covered.</p> | <p>Reports on findings and recommendations are prepared. The Chair forwards these to the Chief Coroner, who forwards them to any relevant agencies or government departments.</p> <p>Recommendations are made public. This must occur within 15 days of review if the child is in care, and the Ministry of Social Development has 45 days to respond.</p> |

| Province/<br>Territory                  | Core team<br>members  | Process   | Age range and<br># of cases<br>reviewed<br>annually   | Sources of data  | Resources   | Outputs  |
|---|---|---|---|--|---|--|
| <p><b>Newfoundland and Labrador</b></p> | <p>Housed in the Office of the Chief Medical Examiner (CME), under the Department of Justice and Public Safety.</p> <p>Eight core members: 3 physicians (one of whom is the CME), a police officer, a nurse, a lawyer, the Executive Director of the Status of Women in Labrador City, and a social worker (committee Chair).</p> <p>Can include ad hoc consultants as necessary.</p> | <p>The CME forwards child death cases to the CDR Chair. The Chair assigns the case to a committee member, who takes the lead in reviewing the case, preparing a case report, and presenting the case at the meeting. The committee meets to review the case and work on the final report. Meetings are held approximately once a month, and they review up to 2 - 3 deaths.</p> | <p>All deaths of children under the age of 19.<sup>12</sup></p> <p>From fall 2014 to January 2016, they have reviewed about 15 cases.</p> | <p>Information from the medical examiner (autopsy information, police report, scene reports, medical reports, etc.).</p> <p>Do not have legislative power to investigate, so all information is obtained from the Office of the CME.</p> | <p>Members from non-governmental agencies receive a small stipend.</p> <p>There are no paid support staff. Costs and administrative support comes from the Office of the CME. Their first year's budget was under \$4000.</p> | <p>Brief report on each case is prepared with findings, conclusions, and recommendations.</p> <p>Report is forwarded to the Minister of Justice, who has to release recommendations to the public and appropriate departments within 60 days (the rest is internal).</p> |

<sup>12</sup> This committee is also mandated to review maternal deaths (any mother who dies as a result of complications related to childbirth).

| Province/<br>Territory | Core team<br>members   | Process  | Age range and<br># of cases<br>reviewed<br>annually  | Sources of data  | Resources  | Outputs   |
|------------------------|--|--|--|--|--|---|
| <b>Ontario</b>         | <p>Deaths Under 5 Committee (DU5C) includes forensic pathologists, coroners, police detectives, child maltreatment and child welfare experts, crown attorneys, a Health Canada product safety specialist, and executive staff from the Office of the Chief Coroner.</p> <p>The two Paediatric Death Review Committees (PDRCs) include pathologists, coroners, medical directors, paediatricians, members from Children’s Aid Societies, police detectives, and executive staff from the Office of the Chief Coroner.</p> | <p>DU5C: all deaths of children under 5 that are investigated by coroners.</p> <p>PDRC - Child Welfare: all deaths of children when the child or their family received services from a Children’s Aid Society within 12 months of the death. All other reviews are done on a discretionary basis and are referred to the PDRC – Medical by the Regional Supervising Coroner or DU5C.</p> <p>Reviews are two-tiered, involving an Executive Team Review and/or Full Committee Review. All identified cases are reviewed at the Executive level. Those that are deemed to require further analysis are then forwarded for a Full Committee Review.</p> | <p>All deaths that fall under their <i>Coroners Act</i>, including all deaths of children under 5 years of age and all deaths of children under 19 with involvement of a Children’s Aid Society within 12 months of their death.</p> <p>In 2014, DU5C did ~ 80 Executive and 60 Full reviews; PDRC – Medical did 12 reviews; PDRC – Child Welfare did 100 Executive and 30 Full reviews.</p> | <p>Reports from the Children’s Aid Society, police reports, forensic pathology reports (post-mortem), and toxicology reports.</p> <p>Committee can request and review medical charts and other records as needed (e.g., school records, records of mental health service providers).</p> | <p>Approximately \$200K - \$250K to support the 3 committees annually (covers ~ 100 Full reviews annually, plus 100 - 120 Executive level reviews).</p> <p>Multiple other “soft” costs (space, supplies, coroner’s involvement).</p> <p>Some members are paid (\$300 per meeting; \$750 per report).</p> <p>One part-time administrative assistant and 2 full-time coordinators.</p> | <p>Reports about individual cases are not released publicly. These reports are shared with the reporting Children’s Aid Society and any other body to whom a recommendation is made. These reports are also shared with families upon request.</p> <p>Annual reports from the DU5C and PDRC are released publicly by the Office of the Chief Coroner.</p> |

| Province/<br>Territory | Core team<br>members  | Process   | Age range and<br># of cases<br>reviewed<br>annually  | Sources of data  | Resources   | Outputs  |
|------------------------|---|---|--|--|---|--|
| <b>Quebec</b>          | <p>Housed in the Office of the Chief Coroner; Crown Prosecutors share the logistics.</p> <p>Members include the police officers, crown prosecutors, the judicial system, the Ministry of Health and Social Services, and a full time investigative coroner.</p> | <p>Review meetings are held once to twice a year. The process is undergoing change as it currently does not have a formal mandate or structure.</p> | <p>All child deaths that are not deemed to be of natural causes are “eventually reviewed”.</p> <p>Approximately 8 to 12 cases are reviewed every year.</p> | <p>Coroner’s files, including police reports, medical charts, interview reports, and administrative investigation reports from partner agencies.</p> | <p>Expenses are covered by members’ own agencies.</p> | <p>No formal recommendations are made, but members bring informal recommendations back to their respective agencies.</p> |

As table 2 highlights, there is a significant degree of inter-provincial variation in how the review processes are structured and in the outputs that are generated. Despite the differences between these provinces, the goals of their CDR processes are generally similar and include the identification of trends or patterns in child death and the identification of preventable risk factors and systemic issues that may contribute to child deaths. These goals and the generation of recommendations to address the identified trends and risk factors are ultimately focused on improving child well-being and preventing similar child deaths in the future.

## 4. Benefits of Provincial CDR Processes

Although formal evaluation does not appear to be built into many of the existing provincial CDR processes, several participants described informal, ongoing monitoring and evaluation of their processes. This ongoing monitoring allows them to make improvements as needed and has also allowed them to identify a number of benefits of having a provincial CDR process. Both anticipated benefits and unexpected benefits were shared by the participants, including the following:

- Allows for the systematic collection of information about who the children are who are dying, when, where, and especially, why children die.
- Can identify trends that require further investigation and research. Identification of trends can also help guide prevention efforts.
- Ensures that no individual death goes unnoticed or “is swept under the rug”.
- Helps to ensure that children are receiving the services they are entitled to.
- Focuses attention on the issues associated with child deaths, including public health and safety issues and those that could affect immediate family members (e.g., child safety or genetic factors).
- Recommendations can lead to changes in practice and policy with the goal of protecting children and preventing future deaths.
- Members of a multidisciplinary committee can bring additional expertise and information to the review table that can supplement that which is provided by the coroner/medical examiner.
- Having a multidisciplinary committee with involvement from a variety of agencies often leads to improved collaboration and communication between these agencies.
- Members informally take lessons from reviews back to their own agencies, which can also lead to the creation of new protocols and processes.

### 4.1 National, Harmonized CDR Process

When asked about harmonizing the CDR process across Canada, a number of participants identified potential benefits of doing so. Several participants suggested that standardized data collection would allow for the determination of national trends and provincial/territorial comparisons. Such information could help guide national conversations on prevention, although one participant noted that standardized data collection could be difficult given jurisdictional differences in mandate and legislation. Another stated benefit was the identification of successful prevention efforts that could be adapted by others (i.e., if one province/territory

shows decreasing child death rates). Similarly, recommendations constructed by one province may be applicable to and useful for other provinces/territories.

Even if the process does not officially become harmonized across Canada, several participants highlighted the importance of using common language and definitions across the country. Currently, different language and definitions are being used, making comparisons difficult. One participant noted that although interprovincial comparisons can be useful, it is most important to focus on the needs of your own province/territory before focusing on national data collection. This participant stated that what works in one province may not work in another province (e.g., may not meet the needs, may not fit the budget). Therefore, it is important to be clear about the goals and the best way to accomplish these with the resources that are available.

## 5. Recommendations and Considerations

Participants involved in a provincial CDR process were asked to share any recommendations or advice they had for the Saskatchewan CDR Advisory Committee to inform their discussions around creating a provincial CDR process. Additional recommendations were spontaneously shared by participants in provinces that do not have a CDR process. The following are key recommendations and considerations that were received from participants.

### Alberta

- Important to streamline the process as much as possible and enable the sharing of information among interested agencies. This reduces overlap increases efficiency, and ensures that the same people are not interviewed repeatedly.
- Access to information is key; Alberta has strong legislation in this regard, which allows investigators at the Office of the Child and Youth Advocate to access the information they need to do their investigations.
- Need to have buy-in from those who will be involved in CDR in the province as well as a shared vision, clear committee structure, and memoranda of understanding between stakeholders.
- CDR process has to be comprehensive across the province and look at the deaths of all children. The process should focus on establishing context, circumstances, and cause/manner of death, in order to direct prevention activities.
- It is critical that the information from reviews be made public (e.g., annual report). This is very important for the process to have value and for credibility.
- Need to look closely at privacy legislation to make sure the committee has necessary access to different types of information.
- Be opportunistic in efforts to establish a committee (e.g., make the most of political opportunities by tailoring advocacy efforts to government priorities).



**British Columbia**

- Before getting too far into the process, it is important to operationalize the process and the different pieces (e.g., what do you mean by CDR? what will the parameters be? what is the purpose of the CDR? what is a file review versus an annual report review versus a death panel review?).
- Volume can be a barrier, so it is important to ensure the goals and procedure of the CDR committee fit within the provided budget.
- Access to information is important. British Columbia's work is covered under the Coroners Act, which allows them to access any information they need to complete their reviews (e.g., can seize data).
- Aggregate reviews are important as they allow for the identification of trends or patterns that can form the basis for recommendations; can be a better use of resources and can provide better recommendations ("rare events make bad policy" – aggregate data allows you to identify if there is something occurring across a number of deaths, rather than a one-off).
- Important that those who will be tasked with implementing recommendations following a review (senior administration people) are also there when recommendations are being drafted; increases the likelihood that recommendations will be implemented.
- Recommendations should be limited to 2-3 to make them actionable; focus on the few important changes that can actually be completed to prevent similar deaths in the future.

**Manitoba**

- Important to ensure that recommendations are practical and directed at the right entities (those who have the capacity to implement them).
- Accessing file information in a timely manner can be a large barrier, slowing down the process and creating backlog.
- Reports need to be timely to ensure that the recommendations are relevant; having a multidisciplinary committee do a full review of every death may create a lot of backlog.
- CDR can only accomplish certain goals; many child deaths are due to deep-seated issues.

**New Brunswick**

- Put careful thought into the age range selected; consider being consistent with other departments or agencies that report deaths. In New Brunswick, the department of Vital Statistics reports on child deaths using three age groupings, the last of which goes up to age 24. It is, therefore, hard to compare their reviewed deaths with provincial numbers (which is desirable since not all deaths are reported to a coroner) without obtaining raw data.
- Do not make the process too strenuous. They hold day-long monthly meetings, and do not want to meet more frequently.
- Put careful thought into who is going to house the committee and how independent it will be from government (independence gives it credibility).
- Look at evidence informed/best practices as the basis for the creation of the committee.

- Good reporting is difficult if the number of child deaths is so small that confidentiality becomes an issue. Protecting people's identities is an important consideration.

### **Newfoundland and Labrador**

- Would recommend using a private information repository (there is one on a provincial government website) for the storage of case information. Such a repository makes information easily accessible to all committee members.
- Think through logistical issues carefully, up front (e.g., information collection and storage, tracking recommendations and having them easily accessible at a later date, what resources are available and who has them).
- Identify a committee leader and where the committee will be housed.
- Important to create a committee that includes those who are essential to have around the table, keeping in mind what potential members can offer. Medical professionals (e.g., pediatricians), lawyers, and police can be extremely important. The capacity to include ad hoc members as needed is very helpful, although it can be difficult to arrange. Aboriginal representation is also important to ensure the appropriate cultural knowledge about cases (Newfoundland and Labrador's Aboriginal representation is ad hoc).
- In small communities, protecting identity can be difficult. Confidentiality is often a concern, although they try to present public recommendations in a way that is general and sanitized.
- Recommendations need to be specific, useful, and appropriate. This can be a challenge if you do not know what protocols, programs, and practices are already happening. It would be ideal to have someone from the appropriate agency involved to have this input.
- Would recommend building into the committee the authority to follow up on implementation of recommendations.
- It is easier to make changes if the committee has the authority to modify or expand the review process without legislative amendment.

### **Northwest Territories**

- Careful consideration should be given when bringing the experts together to be involved in this process. It is important for those involved to have a shared vision, clear committee structure, and a memorandum of understanding between stakeholders.
- It is crucial for all stakeholders to have access and to work together in collaboration for the process to be successful.
- It is important that the report/recommendations are brought forward to the Chief Coroner/Chief Medical Examiner to be made public for value and credibility.

### **Ontario**

- A good starting place would be to start collecting information about all child deaths in Saskatchewan.
- Useful to use a multi-level approach that undertakes analysis at the case level and at the systemic level.

- Effective CDR requires broad availability and collection of data across sectors, used to inform analysis and identify trends.
- Ensure reviews are multi-sectoral, representative of the service spectrum, and include organizations that have influence over public health analysis, policy development, and research and prevention strategies.
- Open information-sharing and collaboration is critical, and can be enabled by protocols and/or legislation across multiple disciplines (e.g., health, education, child welfare, etc.).
- Target high-impact opportunities for prevention that can make a real difference.

### 5.1 Common Themes

There were several common themes in the recommendations listed above. Participants from several provinces noted the importance of creating a shared vision and clarity regarding the process, members' roles, and available resources as the committee is developed. These comments referred to conceptual clarity at the broader level as well as the finer, pragmatic details (e.g., the availability of scanners for uploading documents). These comments are consistent with best practice and CDR committee development recommendations from the National Center for Child Death Review in the United States. This Center has developed a program manual<sup>13</sup> (Covington et al., 2005), which details the process of setting up a CDR committee and important points for discussion in this process. This resource could help to ensure that clarity on all of the important aspects is achieved.

In relation to the structure and functioning of provincial CDR processes, participants highlighted the importance of the committee's access to information. Access to information is achieved by CDR committees through agreements and legislation around information sharing. In British Columbia, for example, the work of the Child Death Review Unit is covered under the *Coroners Act*, which allows them to seize all relevant data if it is not voluntarily provided. Conversely, in Newfoundland and Labrador, lack of investigative power was identified as a barrier (i.e., all of the committee's information is obtained by the medical examiner and must be specifically related to the cause of death). New Brunswick has an intermediate model of information acquisition, whereby case information comes from the coroner (who has a broad range of search and seizure power), but the committee also has the ability to call witnesses to appear before them. Access to a secure file-sharing system that allows all case information to be uploaded and easily accessed by committee members was noted to facilitate the review process.

Multiple respondents noted that CDR committee membership needs to be carefully considered. Having a multidisciplinary committee allows for a more comprehensive and meaningful review process, as members (when chosen carefully) bring unique perspectives and professional expertise to the table. Covington et al. (2005) recommend the inclusion of the following members: law enforcement, child and protective services, prosecutor/district attorney, medical

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<sup>13</sup> <https://www.childdeathreview.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf>

examiner/coroner, public health, pediatrician or other family healthcare provider, and emergency medical services. The specific members on each provincial committee in Canada are listed in Table 2, but generally consist of individuals who bring medical, justice, academic, social, First Nations, and coroner expertise to the review process. Including a First Nations perspective was identified by several participants as important, as it provides the committee with an appropriate cultural perspective during reviews that involve First Nations children. Such inclusion can be done through invitation of ad hoc members or by having regular First Nations membership on the committee. Several respondents identified the ability to invite ad hoc members (e.g., topic experts) to reviews as very important in the establishment of a CDR committee.

Finally, participants provided considerations and advice related to the recommendations put forward by CDR committees. The development of appropriate, achievable recommendations that would be implemented was considered very important, yet challenging, to many of the individuals interviewed. Barriers to effective recommendations included a lack of knowledge regarding what processes and protocols were already in place within human service organizations. This lack of knowledge makes it difficult to create recommendations that are applicable and appropriate (e.g., the recommendations created may target an already existing aspect of practice). Another barrier identified by the participants was the lack of committee authority to follow up on recommendations.

In light of these barriers, respondents had the following advice regarding the recommendations process:

- Include people tasked with implementing recommendations when recommendations are being drafted (i.e., include members of the agency involved and senior administration people).
- Limit recommendations to 2-3 practical, implementable points that are high-impact from a prevention standpoint.
- Ensure that reports are timely so that recommendations remain valid.
- Monitor the implementation of the recommendations.

These suggestions are consistent with best practices for CDR committee recommendations and with existing guidelines for writing effective recommendations (see Covington et al., 2005 for more information). Another possibility, in terms of ensuring successful follow-through with recommendations, is the creation of a two-tiered CDR committee. One tier could be focused primarily on review, and the other focused on the development of recommendations and plans for their implementation. There is some evidence to suggest that when the review process is two-tiered, recommendations are more likely to be implemented (Misra et al., 2004).

## 6. Moving Forward

The information shared in this report reflects the varied landscape of CDR across Canada. Knowledgeable respondents shared the details of CDR processes within their province/territory, as well as the perceived benefits generated by provincial CDR processes. The information summarized in Table 2 provides the key structural and procedural details of provincial CDR processes in Canada. This information is an important reference point for discussions about the potential structure and process of a Saskatchewan CDR committee. The existing models can be considered for their utility given Saskatchewan's current circumstances (existing CDR processes, capacity for and interest in housing a provincial process, available resources for implementing such a process, and annual number of child deaths). These models can also be considered in relation to recommendations from the Canadian Pediatric Society that child death review be legislatively mandated and have broad representation from relevant disciplines; structured processes regarding data collection, reporting, and policy/prevention efforts; systematic data collection, surveillance, and data-sharing; evaluation to determine the effectiveness of processes and recommendations; and appropriate financial support from government bodies (Ornstein et al., 2013).

Importantly, based on their experiences with their own CDR processes, participants described a number of considerations and recommendations for Saskatchewan's CDR Advisory Committee. These considerations and recommendations are described earlier in this report, but were most commonly related to the following: clarity of vision, roles, and process in committee development; having appropriate membership on the committee; ensuring the committee can easily access the information necessary to do a thorough review; and the importance of developing a strong process for recommendations that will achieve the goals of the CDR process. All of these points are structural or procedural and should be considered during the development of a Saskatchewan CDR committee.

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## Appendix A. National Scan Interview Schedule

Hello, my name is \_\_\_\_\_, and I work at the Saskatchewan Prevention Institute. We are currently completing an environmental scan of how child death reviews are conducted across Canada. The information we gather will be shared with the Saskatchewan Child Death Review Advisory Committee to inform their discussions around instituting a universal child death review in our province. The information will also be compiled into a summary report that may be shared on our website ([www.skprevention.ca](http://www.skprevention.ca)) or with others who express an interest in receiving a copy.

**Could you start by describing what is currently happening in terms of child death review in your province?**

*If they do not identify a provincial child death review process in this description* (e.g., fragmented with separate agencies reviewing certain deaths – CFS for children who die in care and hospital reviews for children who die there), record this information but do not ask questions past this section.

Is there a process by which the findings of the different child death reviews are combined? For example, are the findings from the various agencies shared in a cumulative report every few years?

*If not a provincial process*, thank them for their time and end the call.

*If a provincial process is identified*, tell the person being interviewed that we have a number of additional questions to ask. Confirm that they have time to continue the interview.

**Do you have a written mandate that guides your process?**

*If yes*, would we be able to access a copy of that mandate?

**What are the goals of your child death review process?** (e.g., child advocacy, child protection, prevention of future deaths)

**What does your child death review process entail?**

*Ask the follow-up question as needed*

What types of child deaths are reviewed in your province? (What types of child deaths are not reviewed? What ages are reviewed?)

How is the decision made regarding which deaths are reviewed?

Are all deaths given the same level of review?

Who completes these reviews?

What is the structure of your child death review committee? (multidisciplinary?)

What agency hosts the universal child death review?

*If it is the coroner*, Are they in Health or in Justice?

What types of professionals participate in the reviews? (# of committee members? Any ad hoc participants?)

Could you tell me a bit about the structure of the review meetings?  
How often are review meetings held?

What information is collected during a child death review?  
What are the sources of data that feed into your review process? (medical charts, interviews, databases, etc.)  
Do you review individual child death cases or is data collected in aggregate form? (Do you report child death data in aggregate form?)  
Are there systematic (standardized) data collection protocols?  
Who performs the data analysis?  
What is the information that is collected used for?  
Who is the information shared with? (Are reports made publically available?)  
Where is this information stored/by whom?

Does the child death review committee have the authority to make recommendations based on the information collected?

*If yes*, Does the committee have the ability to monitor compliance with the recommendations? (How are any resulting prevention and intervention efforts tracked and evaluated?)

We are also interested in the resources and costs associated with a provincial child death review process.

**Could you tell me about the resource requirements of your child death review process?**

Do you know an estimate of the cost of your child death review? (annual budget)  
Are the expenses and/or time of any committee members paid by the child death review committee?  
Is there paid support staff in addition to committee members?  
What is the information sharing arrangement? (How do they get the data? Do they have to pay for data?)  
How is the child death review funded? (What are your funding sources?)

**Do you know the approximate number of cases reviewed annually?**

The last few questions are focused on the benefits and barriers associated with a child death review process.

**Have you experienced any barriers to the child death review process?** (e.g., privacy acts)

**What are some of the benefits of having a provincial child death review process?** (can be documented benefits or anecdotal)

**Have you experienced any unintended consequences from the child death review process?**

**Has your child death review process been evaluated?**

*If yes*, Are copies of this evaluation available?



**Do you know if there are any plans for changing your current child death review process?**

*If yes, Why do you think these changes are being (will be) implemented?*

**Do you have any recommendations or advice for our committee and our discussions around creating a provincial child death review process in Saskatchewan?**

**Do you see benefits of harmonizing the child death review process or standardizing the information that is collected through child death reviews across Canada?** (This would allow for combining information, comparison, etc.)

**Is there anyone else who you think would be important for us to talk to about child death review in your province?**

*If yes, record names and contact information (if available).*

*Thank them for their time. Provide them with your contact information in case they think of something they would like to add later. Could also email them the list of questions in case there is anything else they would like to add with a bit more time to think about it.*

## Appendix B. Deaths Covered under Provincial and Territorial Acts

Related to Table 1 of the full report, the following is the complete list of deaths that are covered under each provincial and territorial Act.

### Alberta, Fatality Inquiries Act (<http://www.qp.alberta.ca/documents/Acts/F09.pdf>)

#### *Deaths that require notification*

**10(1)** Any person having knowledge or reason to believe that a person has died under any of the circumstances referred to in subsection (2) or section 11, 12 or 13 shall immediately notify a medical examiner or an investigator.

**(2)** Deaths that occur under any of the following circumstances require notification under subsection (1):

- (a) deaths that occur unexplainedly;
- (b) deaths that occur unexpectedly when the deceased was in apparent good health;
- (c) deaths that occur as the result of violence, accident or suicide;
- (d) maternal deaths that occur during or following pregnancy and that might reasonably be related to pregnancy;
- (e) deaths that may have occurred as the result of improper or negligent treatment by any person;
- (f) deaths that occur
  - (i) during an operative procedure,
  - (ii) within 10 days after an operative procedure,
  - (iii) while under anesthesia, or
  - (iv) any time after anesthesia and that may reasonably be attributed to that anesthesia;
- (g) deaths that are the result of poisoning;
- (h) deaths that occur while the deceased person was not under the care of a physician;
- (i) deaths that occur while the deceased person was in the custody of a peace officer or as a result of the use of force by a peace officer while on duty;
- (j) deaths that are due to
  - (i) any disease or ill-health contracted or incurred by the deceased,
  - (ii) any injury sustained by the deceased, or
  - (iii) any toxic substance introduced into the deceased,as a direct result of the deceased's employment or occupation or in the course of one or more of the deceased's former employments or occupations.

*Notification of death of prisoner***11** If a person dies while

- (a) detained in a correctional institution as defined in the *Corrections Act* or a jail, including a military guard room, remand centre, penitentiary, secure services facility as defined in the *Child, Youth and Family Enhancement Act*, facility or place designated as a place of open or secure custody pursuant to the *Youth Criminal Justice Act* (Canada), detention centre or a place where a person is held under a warrant of a judge,
  - (b) a formal patient in any facility as defined by the *Mental Health Act*, or
  - (c) an inmate or patient in any institution specified in the regulations,
- the person in charge of that institution, jail, facility or other place shall immediately notify a medical examiner.

*Notification of death of prisoner not in custody***12** If a person dies while

- (a) committed to a correctional institution as defined in the *Corrections Act* or a jail, including a military guard room, remand centre, penitentiary, secure services facility as defined in the *Child, Youth and Family Enhancement Act*, facility or place designated as a place of open or secure custody pursuant to the *Youth Criminal Justice Act* (Canada), detention centre or a place where a person is held under a warrant of a judge,
  - (b) a formal patient in any facility as defined by the *Mental Health Act*, or
  - (c) an inmate or patient in any institution specified in the regulations,
- but while not on the premises or in actual custody of that facility or institution, jail or other place, the person in charge of that facility or institution, jail or other place, shall, immediately on receiving notice of the death, notify a medical examiner.

*Notification of death of child*

**13** A director under the *Child, Youth and Family Enhancement Act* shall immediately notify a medical examiner of the death of any child under the director's guardianship or in the director's custody.

**British Columbia, Coroners Act**

([http://www.bclaws.ca/civix/document/id/complete/statreg/07015\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/07015_01))

*Deaths that must be reported by anyone*

**2(1)** A person must immediately report to a coroner or peace officer the facts and circumstances relating to the death of an adult or child who the person has reason to believe has died

- (a) as a result of violence, accident, negligence, misconduct or malpractice,
- (b) as a result of a self-inflicted illness or injury,
- (c) suddenly and unexpectedly, when the person was apparently in good health and not under the care of a medical practitioner or nurse practitioner,
- (d) from disease, sickness or unknown cause, for which the person was not treated by a medical practitioner or nurse practitioner,
- (e) during pregnancy, or following pregnancy in circumstances that might reasonably be attributable to pregnancy,

- (f) if the chief coroner reasonably believes it is in the public interest that a class of deaths be reported and issues a notice in accordance with the regulations, in the circumstances set out in the notice, or
- (g) in any prescribed circumstances.

**(2)** If a child died in circumstances other than those described in subsection (1), a person who, by regulation, must report child deaths, must immediately report to the chief coroner, in the form required by the chief coroner,

- (a) the facts and circumstances relating to the child's death, and
- (b) any other information required by the chief coroner.

### **Child death review unit**

**47(1)** The chief coroner must establish a child death review unit to review the facts and circumstances of child deaths in British Columbia for the purposes of

- (a) discovering and monitoring trends in child deaths, and
- (b) determining whether further evaluation of the death of a child is necessary or desirable in the public interest.

**(2)** The chief coroner may appoint, in accordance with the *Public Service Act*, one or more persons to the child death review unit to exercise the powers and perform the duties of the child death review unit.

**(3)** The chief coroner must appoint one member of the child death review unit to act as chair of the child death review unit.

### *Powers of child death review unit*

**48(1)** A member of the child death review unit may review one or more deaths during a review.

**(2)** A member of the child death review unit must not begin a review until a coroner has completed,

- (a) if no inquest is held, the coroner's investigation, or
  - (b) if an inquest is held, the inquest
- and the conditions of section 44 (1) [when investigative powers end] have been met.

**(3)** For the purposes of conducting a review, a member of the child death review unit may

- (a) use any information acquired through an investigation or inquest conducted under this Act, whether or not the investigation or inquest was completed, and
- (b) exercise the powers of investigation set out in section 11 as if the member were a coroner conducting an investigation.

*Death review panels*

**49(1)** The chief coroner may, and at the direction of the minister must, establish panels to review the facts and circumstances of deaths, including child deaths, in British Columbia for the purposes of providing advice to the chief coroner respecting

- (a) medical, legal, social welfare and other matters that may impact public health and safety, and
- (b) the prevention of deaths.

**(2)** If the chief coroner establishes a death review panel, the chief coroner may

- (a) appoint a person to act as chair of the death review panel,
- (b) appoint one or more persons to the death review panel and set the terms of the appointment, including remuneration, if any, and
- (c) set the terms of reference for the death review panel.

*Powers of death review panels*

**50(1)** A member of a death review panel may review one or more deaths during a review.

**(2)** A member of a death review panel may begin a review

- (a) before, during or after an investigation or inquest, or a review conducted by the child death review unit, and
- (b) regardless of any decision made by a coroner or a member of the child death review unit.

**(3)** For the purposes of conducting a review, a member of a death review panel may use any information disclosed to the member by the chief coroner.

*Report of review*

**51(1)** Following each review by the child death review unit or a death review panel, a member of the child death review unit or the death review panel, as applicable, must

- (a) report to the chief coroner
  - (i) any findings respecting the circumstances surrounding deaths that were the subject of a review, and
  - (ii) any recommendations respecting the prevention of similar deaths, and
- (b) submit to the chief coroner all records relevant to the review.

**(2)** A member of the child death review unit or a death review panel may base his or her report on an aggregate and multidisciplinary analysis of the deaths reviewed.

**(3)** A member of the child death review unit may make recommendations to the chief coroner respecting the protection of the health, safety and well-being of children generally.

**(4)** A member of the child death review unit or a death review panel must not, in his or her report, make any finding of legal responsibility or express any conclusion of law.

**Manitoba, Fatality Inquiries Act** ([https://web2.gov.mb.ca/laws/statutes/ccsm/\\_pdf.php?cap=f52](https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=f52))

*Inquiry as to deaths*

**7(5)** Where a medical examiner or investigator learns of a death to which clause (9)(a), (b), (c) or (d) applies and the body is in the province, the medical examiner or investigator shall immediately take charge of the body, inform the police of the death and make prompt inquiry with respect to

- (a) the cause of death;
  - (b) the manner of death;
  - (c) the identity and age of the deceased;
  - (d) the date, time and place of death;
  - (e) the circumstances under which the death occurred; and
  - (f) subject to subsection 9(2), whether the death warrants an investigation;
- and shall submit an inquiry report on the above matters to the chief medical examiner and where the medical examiner or investigator decides that the death warrants an investigation, the medical examiner or investigator shall provide the reasons for the decision.

*Deaths to which subsection (5) applies*

**7(9)** Subsection (5) applies to a death where

- (a) the deceased person died
  - (i) as a result of an accident,
  - (ii) by an act of suicide, negligence or homicide,
  - (iii) in an unexpected or unexplained manner,
  - (iv) as a result of poisoning,
  - (v) as a result of contracting a contagious disease that is a threat to public health,
  - (vi) suddenly of unknown cause,
  - (vii) during a pregnancy or during recovery from a pregnancy,
  - (viii) while under anesthesia or while recovering from an anesthesia or within 10 days of a surgical operation performed upon the person,
  - (ix) while in the custody of a peace officer,
  - (x) as a result of
    - (A) contracting a disease or condition,
    - (B) sustaining an injury, or
    - (C) ingesting a toxic substance,
  - at the place of employment or former employment of the person,
  - (xi) within 24 hours of admission of the person to a hospital,
  - (xii) in a place, institution or facility that is prescribed or is of a class of place, institution or facility that is prescribed, or
  - (xiii) in circumstances that are prescribed;
- (b) at the time of death, the deceased person
  - (i) was not under the care of a duly qualified medical practitioner for the condition that brought on the death, or

- (ii) was a resident of an institution or care facility that is licensed, or is required by an Act of the Legislature to be licensed, to operate as a residential institution or care facility;
- (c) the deceased person died while a resident in a correctional institution, jail, prison or military guardroom, in a psychiatric facility as defined in *The Mental Health Act* or in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act*; or
- (d) the deceased person is a child.

*Mandatory investigation on death of child*

**9(2)** In the case of a death of a child that might be the result of an accident, suicide, homicide or other unnatural cause, an investigation is warranted and must be commenced in accordance with clause (1)(a) or (b).

*Child's death to be reported to children's advocate*

**10(1)** Upon learning that a child has died in Manitoba, the chief medical examiner must notify the children's advocate under *The Child and Family Services Act* of that death.

*Reports to be given to children's advocate*

**10(2)** If the children's advocate has jurisdiction to conduct a review under section 8.2.3 of *The Child and Family Services Act* in relation to the death of a child in Manitoba, the chief medical examiner must provide to the children's advocate, upon request,

- (a) a copy of the medical examiner's report on the manner and cause of death; and
- (b) a copy of the final autopsy report, if one has been ordered by the medical examiner and the children's advocate requires it for the review.

*Reports are confidential*

**10(3)** The information provided to the children's advocate under subsection (2) must not be used except for the purpose of a review and report under section 8.2.3 of *The Child and Family Services Act*, and must not be disclosed in that report except as necessary to support the findings and recommendations made in that report.

**New Brunswick, Coroners Act** (<http://canlii.ca/t/88px>)

**4** Every person who has reason to believe that a person died

- (a) as a result of
  - (i) violence,
  - (ii) misadventure,
  - (iii) negligence,
  - (iv) misconduct, or
  - (v) malpractice;
- (a.1) during pregnancy or following pregnancy in circumstances that might reasonably be attributable to the pregnancy;
- (a.2) suddenly and unexpectedly;

- (a.3) from disease or sickness for which there was no treatment given by a medical practitioner;
- (b) from any cause other than disease or natural causes; or
- (c) under such circumstances as may require investigation;

shall, unless he knows that a coroner has already been notified, immediately notify a coroner of the facts and circumstances relating to the death.

**6(1)** Where a person dies while a prisoner in a penitentiary, jail, correctional institution, place of secure custody or place of temporary detention, the person in charge of the penitentiary, jail, correctional institution, place of secure custody or place of temporary detention shall immediately give notice of the death to the Chief Coroner.

**6(2)** Where a person dies while in custody pursuant to the *Family Services Act*, *Intoxicated Persons Detention Act*, *Mental Health Act* or while under arrest for an offence or an alleged offence against any statute of Canada or New Brunswick, the person having actual custody of such person shall immediately give notice of the death to the Chief Coroner.

**6.1** An employer shall immediately give notice to a coroner of the death of a worker who died as a result of an accident occurring in the course of his or her employment at or in a woodland operation, sawmill, lumber processing plant, food processing plant, fish processing plant, construction project site, mining plant or mine, including a pit or quarry.

### **Newfoundland and Labrador, Fatalities Investigations Act**

(<http://www.assembly.nl.ca/Legislation/sr/statutes/f06-1.htm#5>)

#### *Notice of death*

- 5.** A person having knowledge of or reason to believe that a person has died under one of the following circumstances shall immediately notify a medical examiner or an investigator:
- (a) as a result of violence, accident or suicide;
  - (b) unexpectedly when the person was in good health;
  - (c) where the person was not under the care of a physician;
  - (d) where the cause of death is undetermined; or
  - (e) as the result of improper or suspected negligent treatment by a person.

#### *Deaths that occur in a facility*

**6.(1)** Where a person dies while in a health care facility, or another place where patients are received for treatment or care and there is reason to believe that

- (a) the death occurred as the result of violence, attempted suicide or accident, no matter how long the patient had been hospitalized;
- (b) the death occurred as a result of suspected misadventure, negligence or accident on the part of the attending physician or staff;
- (c) the cause of death is undetermined;
- (d) the death occurred during or following pregnancy in circumstances that might reasonably be related to pregnancy;



(e) a stillbirth or a neonatal death has occurred where maternal injury has occurred or is suspected, either prior to admission or during delivery; or

(f) the death occurred within 10 days of an operative procedure or the patient is under initial induction, under anaesthesia or during the recovery from anaesthesia,

the person responsible for that facility shall immediately notify a medical examiner or an investigator.

**(2)** Where a person is declared dead on arrival or dies in the emergency department of a health care facility as a result of a condition referred to in section 5, the person responsible for that facility shall immediately notify a medical examiner or an investigator.

#### *Institutional deaths*

##### **7.** Where a person dies

(a) while detained in a correctional institution, such as a jail, penitentiary, guard room, remand centre, detention centre, youth facility, lock-up or any other place where a person is in custody;

(b) while an inmate or patient in treatment facilities or parts, or psychiatric divisions of treatment facilities or parts, or classes of treatment facilities designated under the *Mental Health Care and Treatment Act* ;

(c) while in the custody of a manager under the *Children and Youth Care and Protection Act* ; or

(d) while in the custody of a peace officer,

the person in charge of that institution or the person having the custody of that person shall immediately notify a medical examiner or an investigator.

#### *Employment related deaths*

##### **8.** Where a person dies as the result of

(a) a disease or ill-health;

(b) an injury sustained by the person; or

(c) a toxic substance introduced into the person,

probably caused by the person's employment or occupation or in the course of one or more of his or her former employments or occupations, the person attending the person shall immediately notify a medical examiner or an investigator.

#### *Child Death Review Committee*

**13.1 (1)** The Lieutenant-Governor in Council shall establish a Child Death Review Committee to review the facts and circumstances of deaths referred to in subsection 13.2(1) for the purpose of

(a) discovering and monitoring trends in those deaths; and

(b) determining whether further evaluation of those deaths is necessary or desirable in the public interest.

**(2)** The membership of the committee shall be determined by the Lieutenant-Governor in Council.

**(3)** The Lieutenant-Governor in Council shall appoint one member as chairperson and one member as vice-chairperson who shall act as chairperson where the chairperson is absent or unable to act.

**(4)** The chief medical examiner shall, by virtue of his or her office, be a member of the committee.

**(5)** A committee member shall be appointed for the term prescribed by the Lieutenant-Governor in Council, and notwithstanding the expiration of a committee member's term, that person shall continue to serve on the committee until reappointed or replaced.

**(6)** In the discretion of the chairperson of the committee, some or all of the members of the committee may perform a review.

**(7)** Notwithstanding subsection (6), where a committee member wishes to participate in a review he or she shall not be prohibited from doing so except where, in the opinion of the chairperson, that committee member is in a position of conflict or potential conflict with respect to the review.

**(8)** Notwithstanding subsection (6), all of the members of the committee shall meet at least annually.

**(9)** The committee may, with the prior approval of the minister, obtain assistance or retain expert services in the course of a review, and a person providing that assistance or whose services are retained shall be considered to be a member of the committee for the purpose of that review.

#### *Review by committee*

**13.2 (1)** The committee shall review the facts and circumstances of

- (a) child deaths; and
- (b) deaths referred to in paragraphs 6(1)(d) and (e)

where those deaths are required to be investigated by the medical examiner under subsection 10(1).

**(2)** The committee may review one or more deaths during a review.

**(3)** A review shall only begin after a medical examiner has completed his or her duties under section 10.

**(4)** For the purpose of conducting a review, the committee may use any information acquired by a medical examiner or investigator in the course of an investigation under this Act.

#### *Report of committee*

**13.3 (1)** After each review, the committee shall report to the minister

- (a) its findings with respect to the facts and circumstances surrounding deaths that were the subject of the review; and
- (b) the recommendations it may have respecting the prevention of similar deaths.

**(2)** The committee may base its report on an aggregate and multidisciplinary analysis of the deaths reviewed.

**(3)** In its report, the committee may

- (a) identify systemic problems;
- (b) promote prevention of deaths reviewed by it through education, protocol development and dissemination of information; and
- (c) make recommendations to the minister respecting the protection of the health, safety and well-being of children and pregnant women generally.

**(4)** The committee shall not, in its report, make a finding of legal responsibility or express a conclusion of law.

**(5)** After a report has been submitted to the minister under this section, the committee shall submit all records relevant to the review to the Chief Medical Examiner.

*Minister to provide copy*

**13.4** The minister shall as soon as practicable provide a copy of the report of the committee to the Child and Youth Advocate.

*Recommendations to be made public*

**13.5** Within 60 days after the minister has received a report under section 13.3, the minister shall make public those recommendations of the report relating to

- (a) relevant protocols, policies and procedures;
- (b) standards and legislation;
- (c) linkages and coordination of services; and
- (d) improvements to services affecting children and pregnant women.

**Northwest Territories, Coroners Act**

(<https://www.justice.gov.nt.ca/en/files/legislation/coroners/coroners.a.pdf>)

*Reporting of deaths, Duty to notify*

**8. (1)** Every person shall immediately notify a coroner or a police officer of any death of which he or she has knowledge that occurs in the Northwest Territories, or as a result of events that occur in the Territories, where the death

- (a) occurs as a result of apparent violence, accident, suicide or other apparent cause other than disease, sickness or old age;
- (b) occurs as a result of apparent negligence, misconduct or malpractice;
- (c) occurs suddenly and unexpectedly when the deceased was in apparent good health;
- (d) occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia;
- (e) occurs as a result of
  - (i) a disease or sickness incurred or contracted by the deceased,

- (ii) an injury sustained by the deceased, or
- (iii) an exposure of the deceased to a toxic substance, as result or in the course of any employment or occupation of the deceased;
- (f) is a stillbirth that occurs without the presence of a medical practitioner;
- (g) occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or
- (h) occurs while the deceased is detained by or in the custody of a police officer.

### **Nova Scotia, Fatality Investigations Act**

(<http://nslegislature.ca/legc/statutes/fatality%20investigations.pdf>)

#### *Duty to notify of death*

**9** A person having knowledge of or reason to believe that a person has died under one of the following circumstances shall immediately notify a medical examiner or an investigator:

- (a) as a result of violence, accident or suicide;
- (b) unexpectedly when the person was in good health;
- (c) where the person was not under the care of a physician;
- (d) where the cause of death is undetermined; or
- (e) as the result of improper or suspected negligent treatment by a person. 2001, c. 31, s. 9.

#### *Death in health-care facility*

**10(1)** Where a person dies while in a health-care facility and there is reason to believe that

- (a) the death occurred as the result of violence, suspected suicide or accident;
- (b) the death occurred as a result of suspected misadventure, negligence or accident on the part of the attending physician or staff;
- (c) the cause of death is undetermined;
- (d) a stillbirth or a neonatal death has occurred where maternal injury has occurred or is suspected either before admission or during delivery; or
- (e) the death occurred within ten days of an operative procedure or under initial induction, anaesthesia or the recovery from anaesthesia from that operative procedure,

the person responsible for that facility shall immediately notify a medical examiner or an investigator.

**(2)** Where a person is declared dead on arrival or dies in the emergency department of a health-care facility as a result of a circumstance referred to in subsection (1), the person responsible for that facility shall immediately notify a medical examiner or an investigator.

#### *Death in custody or detention*

**11(1)** Where a person dies

- (a) while detained or in custody in a correctional institution such as a jail, penitentiary, guard room, remand centre, detention centre, youth facility, lock-up or any other place where a person is in custody or detention;
- (b) while an inmate who is in a hospital or a facility as defined in the *Hospitals Act*;

- (c) in an institution designated in the regulations;
- (d) while in the custody of the Minister of Community Services pursuant to the *Children and Family Services Act*; or
- (e) while detained by or in the custody of a peace officer or as a result of the use of force by a peace officer while on duty,

the person in charge of that institution or the person detaining or having the custody of the deceased person shall immediately notify a medical examiner or an investigator.

**(2)** Where a person dies while committed to a facility or institution set out in subsection (1) but while not on the premises or in actual custody, the person in charge of that facility or institution, jail or other place shall, immediately on receiving notice of the death, notify a medical examiner.

#### *Death probably related to employment or occupation*

**12** Where a person dies as the result of

- (a) a disease or ill health;
- (b) an injury sustained by the person; or
- (c) a toxic substance introduced into the person,

probably caused by or connected with the person's employment or occupation, the physician attending the deceased person at the time of that person's death shall immediately notify a medical examiner or an investigator.

#### **Nunavut, Coroners Act** (<http://www.gov.nu.ca/coroners-act>)

##### *Reporting of deaths, Duty to notify*

**8. (1)** Every person shall immediately notify a coroner or a police officer of any death of which he or she has knowledge that occurs in the Territories, or as a result of events that occur in the Territories, where the death

- (a) occurs as a result of apparent violence, accident, suicide or other apparent cause other than disease, sickness or old age;
- (b) occurs as a result of apparent negligence, misconduct or malpractice;
- (c) occurs suddenly and unexpectedly when the deceased was in apparent good health;
- (d) occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia;
- (e) occurs as a result of
  - (i) a disease or sickness incurred or contracted by the deceased,
  - (ii) an injury sustained by the deceased, or
  - (iii) an exposure of the deceased to a toxic substance, as result or in the course of any employment or occupation of the deceased;
- (f) is a stillbirth that occurs without the presence of a medical practitioner;
- (g) occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or
- (h) occurs while the deceased is detained by or in the custody of a police officer.

**Ontario, Coroners Act** (<https://www.ontario.ca/laws/statute/90c37>)*Duty to give information*

- 10. (1)** Every person who has reason to believe that a deceased person died,
- (a) as a result of,
    - (i) violence,
    - (ii) misadventure,
    - (iii) negligence,
    - (iv) misconduct, or
    - (v) malpractice;
  - (b) by unfair means;
  - (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable thereto;
  - (d) suddenly and unexpectedly;
  - (e) from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
  - (f) from any cause other than disease; or
  - (g) under such circumstances as may require investigation,
- shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances.

*Deaths to be reported*

- (2)** Where a person dies while resident or an in-patient in,
- (a) REPEALED: 2007, c. 8, s. 201 (1).
  - (b) a children's residence under Part IX (Licensing) of the Child and Family Services Act or premises approved under subsection 9 (1) of Part I (Flexible Services) of that Act;
  - (c) REPEALED: 1994, c. 27, s. 136 (1).
  - (d) a supported group living residence or an intensive support residence under the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008;
  - (e) a psychiatric facility designated under the Mental Health Act;
  - (f) REPEALED: 2009, c. 33, Sched. 18, s. 6.
  - (g) REPEALED: 1994, c. 27, s. 136 (1).
  - (h) a public or private hospital to which the person was transferred from a facility, institution or home referred to in clauses (a) to (g),
- the person in charge of the hospital, facility, institution, residence or home shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.

*Deaths in long-term care homes*

- (2.1)** Where a person dies while resident in a long-term care home to which the Long-Term Care Homes Act, 2007 applies, the person in charge of the home shall immediately give notice of the

death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, he or she shall investigate the circumstances of the death and if, as a result of the investigation, he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.

*Deaths off premises of psychiatric facilities, correctional institutions, youth custody facilities*

**(3)** Where a person dies while,

(a) a patient of a psychiatric facility;

(b) committed to a correctional institution;

(c) committed to a place of temporary detention under the *Youth Criminal Justice Act* (Canada);

or

(d) committed to secure or open custody under section 24.1 of the *Young Offenders Act* (Canada), whether in accordance with section 88 of the *Youth Criminal Justice Act* (Canada) or otherwise,

but while not on the premises or in actual custody of the facility, institution or place, as the case may be, subsection (2) applies as if the person were a resident of an institution named in subsection (2).

*Death on premises of detention facility or lock-up*

**(4)** Where a person dies while detained in and on the premises of a detention facility established under section 16.1 of the *Police Services Act* or a lock-up, the officer in charge of the facility or lock-up shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body.

*Death on premises of place of temporary detention*

**(4.1)** Where a person dies while committed to and on the premises of a place of temporary detention under the *Youth Criminal Justice Act* (Canada), the officer in charge of the place shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body.

*Death on premises of place of secure custody*

**(4.2)** Where a person dies while committed to and on the premises of a place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada), whether in accordance with section 88 of the *Youth Criminal Justice Act* (Canada) or otherwise, the officer in charge of the place or facility shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body.

*Death on premises of correctional institution*

**(4.3)** Where a person dies while committed to and on the premises of a correctional institution, the officer in charge of the institution shall immediately give notice of the death to a coroner and the coroner shall investigate the circumstances of the death and shall hold an inquest upon the body if

as a result of the investigation he or she is of the opinion that the person may not have died of natural causes.

*Death in custody off premises of correctional institution*

**(4.5)** Where a person dies while committed to a correctional institution, while off the premises of the institution and while in the actual custody of a person employed at the institution, the officer in charge of the institution shall immediately give notice of the death to a coroner and the coroner shall investigate the circumstances of the death and shall hold an inquest upon the body if as a result of the investigation he or she is of the opinion that the person may not have died of natural causes.

*Other deaths in custody*

**(4.6)** If a person dies while detained by or in the actual custody of a peace officer and subsections (4), (4.1), (4.2), (4.3) and (4.5) do not apply, the peace officer shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body.

*Death while restrained on premises of psychiatric facility, etc.*

**(4.7)** Where a person dies while being restrained and while detained in and on the premises of a psychiatric facility within the meaning of the *Mental Health Act* or a hospital within the meaning of Part XX.1 (Mental Disorder) of the Criminal Code (Canada), the officer in charge of the psychiatric facility or the person in charge of the hospital, as the case may be, shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body.

*Death while restrained in secure treatment program*

**(4.8)** Where a person dies while being restrained and while committed or admitted to a secure treatment program within the meaning of Part VI of the Child and Family Services Act, the person in charge of the program shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body.

*Notice of death resulting from accident at or in construction project, mining plant or mine*

**(5)** Where a worker dies as a result of an accident occurring in the course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry, the person in charge of such project, mining plant or mine shall immediately give notice of the death to a coroner and the coroner shall hold an inquest upon the body.

*Inquest mandatory*

**22.1** A coroner shall hold an inquest under this Act into the death of a child upon learning that the child died in the circumstances described in clauses 72.2 (a), (b) and (c) of the *Child and Family Services Act*.



**Prince Edward Island, Coroners Act** ([http://www.gov.pe.ca/law/statutes/pdf/c-25\\_1.pdf](http://www.gov.pe.ca/law/statutes/pdf/c-25_1.pdf))*Duty to report death to coroner*

- 5.(1)** Where a death has occurred in the province, or as a result of events that occurred in the province, every person shall immediately report the death to a coroner or a police officer, if the person has reason to believe that the death
- (a) occurred as a result of violence, accident, suicide or other cause other than disease, sickness or old age;
  - (b) occurred as a result of negligence, misconduct or malpractice;
  - (c) occurred suddenly and unexpectedly when the deceased had been in apparent good health;
  - (d) occurred under circumstances in which the body is not available because the body or part of the body
    - (i) has been destroyed,
    - (ii) is in a place from which it cannot be recovered, or
    - (iii) cannot be located;
  - (e) occurred within 10 days after a surgical procedure or while the deceased was under or recovering from anaesthesia;
  - (f) occurred as a direct or immediate consequence of the deceased being engaged in employment, an occupation or a business;
  - (g) was a stillbirth that occurred without the presence of a duly qualified medical practitioner;
  - (h) occurred while the deceased was detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution;
  - (i) occurred while the deceased was detained by or in the custody of a police officer;
  - (j) occurred while the deceased was under the care, custody or supervision of the Director of Child Protection; or
  - (k) occurred in circumstances that require investigation.

**Quebec, Coroners Act**

([http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C\\_68/C68\\_A.html](http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C_68/C68_A.html))

*Information to Coroner*

- 9.** Whosoever knows or learns that a person died suddenly or violently or from negligent or culpable conduct of some other person, or from causes unknown or of a suspicious nature or which do not appear to be natural, shall forthwith so inform the coroner of the district where the body was found.
- 10.** When a person dies while confined in a penitentiary, house of detention, or in an institution for the mentally ill, it shall be the duty of the warden, gaoler, superintendent or person in charge of such institution, to notify the coroner immediately, detailing the circumstances connected with such death.

**Saskatchewan, Coroners Act** (<http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/C38-01.pdf>)*Duty to Notify Coroner of a Death, General duty to notify coroner*

**7(1)** Every person shall immediately notify a coroner or a peace officer of any death that the person knows or has reason to believe:

- (a) occurred as a result of an accident or violence or was self-inflicted;
- (b) occurred from a cause other than disease or sickness;
- (c) occurred as a result of negligence, misconduct or malpractice on the part of others;
- (d) occurred suddenly and unexpectedly when the deceased appeared to be in good health;
- (e) occurred in Saskatchewan under circumstances in which the body is not available because:
  - (i) the body or part of the body has been destroyed;
  - (ii) the body is in a place from which it cannot be recovered; or
  - (iii) the body cannot be located;
- (f) was a stillbirth that occurred without the presence of a duly qualified medical practitioner;
- (g) occurred as a direct or immediate consequence of the deceased being engaged in employment, an occupation or a business; or
- (h) occurred under circumstances that require investigation.

**(2)** Every peace officer who is notified of a death pursuant to subsection (1) shall immediately notify a coroner of the death.

*Duty of institutions to notify coroner*

**8(1)** Where an inmate of a jail, military guardroom, remand centre, penitentiary, lock-up or place where the person is held under a warrant of a judge or a correctional facility as defined in *The Correctional Services Act, 2012* dies, the person in charge of that place shall immediately notify a coroner of the death.

**(2)** Where a person dies while in a custody facility as defined in *The Youth Justice Administration Act*, the person in charge of that facility shall immediately notify a coroner of the death.

**(3)** Where a minor dies while a resident of a foster home, group home or place of safety within the meaning of *The Child and Family Services Act*, the person in charge of that place shall immediately notify a coroner of the death.

**(4)** Where an involuntary patient admitted pursuant to section 23 or 24, or detained pursuant to section 24.1, of *The Mental Health Services Act* to an inpatient facility within the meaning of that Act dies, the person in charge of that facility shall immediately notify a coroner of the death.

**(5)** The duty mentioned in this section applies whether or not:

- (a) the person died on the premises or in actual custody; or
- (b) the person was an inmate, resident or patient at the time of death if the death was caused at that place.

**(6)** Where a person dies while in a hospital to which the person was transferred from a place mentioned in this section, the person in charge of the hospital shall immediately notify the coroner of the death.

*Duty of police to notify coroner*

**9** Where a person dies as a result of an act or omission of a peace officer in the course of duty or while detained by or in the custody of a peace officer, the peace officer shall immediately notify a coroner of the death.

*Duty of social workers to notify coroner*

**10** Where a minor dies while under the care, custody or supervision of the Minister of Community Resources and Employment, officers or employees of the Department of Community Resources and Employment or its designates or an agency that has entered into an agreement with the Minister of Community Resources and Employment pursuant to section 61 of *The Child and Family Services Act*, an officer or employee of the Department of Community Resources and Employment, its designate or the agency who has knowledge of the death shall immediately notify a coroner of the death.

**Yukon, Coroners Act** (<http://www.gov.yk.ca/legislation/acts/coroners.pdf>)

*Duty to notify coroner of death*

**5** A medical practitioner, undertaker, embalmer, peace officer or any person residing in the house in which the deceased resided immediately before death or any other person who has reason to believe that a deceased person died as a result of violence, misadventure or unfair means, from any cause other than disease or sickness, as a result of negligence, misconduct or malpractice on the part of others or under any other circumstances that require investigation shall immediately notify the coroner who ordinarily has jurisdiction in the locality in which the body of the deceased person is found, of the circumstances relating to the death.

## Appendix C. Process for Child Deaths as Stipulated by Provincial and Territorial Child and Youth Advocate Acts

**Alberta, Child and Youth Advocate Act** (<http://www.qp.alberta.ca/documents/Acts/c11p5.pdf>)

### *Definitions*

**(1)** In this Act,

(e) “designated service” means

- (i) a service under the Child, Youth and Family Enhancement Act, other than an adoption service under Part 2 of that Act,
- (ii) a service under the Protection of Sexually Exploited Children Act, or
- (iii) a service provided to children in the youth criminal justice system;

### *Role and functions of Advocate*

**9(2)** In carrying out the role of the Advocate under subsection (1), the Advocate may

(d) if, in the opinion of the Advocate, the investigation is warranted or in the public interest, investigate systemic issues arising from

- (ii) a serious injury to or the death of a child who at the time of the injury or death was receiving a designated service referred to in section 1(e)(ii) or (iii),
- (iii) the death of a child who at the time of the death was receiving a designated service referred to in section 1(e)(i), or
- (iv) the death of a child who at any time during the 2-year period immediately preceding the death received a designated service referred to in section 1(e)(i)

### *Duty to report*

**12(1)** When a child is seriously injured or dies while receiving a designated service, the public body responsible for the provision of the designated service shall report the incident to the Advocate as soon as practicable.

### *Powers relating to investigations*

**14** In conducting an investigation under section 9(2)(d), the Advocate has all the powers, privileges and immunities of a commissioner under the Public Inquiries Act.

### *Report after investigation*

**15(1)** Where the Advocate conducts an investigation under section 9(2)(d), the Advocate must, after completing the investigation, make a report

- (a) containing recommendations for any public body or other person as the Advocate considers appropriate, and
- (b) addressing any other matters the Advocate considers appropriate.

- (2)** The findings of the Advocate shall not contain any findings of legal responsibility or any conclusions of law.
- (3)** A report made under subsection (1) must not disclose the name of, or any identifying information about, the child to whom the investigation relates or a parent or guardian of the child.
- (4)** The Advocate must provide a copy of a report made under subsection (1) to a public body that is directly or indirectly a subject of the investigation.
- (5)** The Advocate must make a report made under subsection (1) available to the public at a time and in a form and manner that the Advocate considers appropriate.

### **British Columbia, Representative for Children and Youth Act**

[http://www.bclaws.ca/EPLibraries/bclaws\\_new/document/ID/freeside/00\\_06029\\_01#section11](http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_06029_01#section11)

#### *Definitions*

**1** In this Act:

"designated services" means any of the following services or programs for children and their families provided under an enactment or provided or funded by the government:

- (a) services or programs under the Adoption Act, the Child Care BC Act, the Child Care Subsidy Act, the Child, Family and Community Service Act, the Community Living Authority Act and the Youth Justice Act;
- (b) early childhood development and child care services;
- (c) mental health services for children;
- (d) addiction services for children;
- (e) services for youth and young adults during their transition to adulthood;
- (f) additional services or programs that are prescribed under section 29 (2) (a);

"reviewable services" means any of the following designated services:

- (a) services or programs under the Child, Family and Community Service Act and the Youth Justice Act;
- (b) mental health services for children;
- (b.1) addiction services for children;
- (c) additional designated services that are prescribed under section 29 (2) (b)

#### *Functions of representative*

**6 (1)** The representative is responsible for performing the following functions in accordance with this Act:

- (c) review, investigate and report on the critical injuries and deaths of children as set out in Part 4;

*Part 4 — Reviews and Investigations of Critical Injuries and Deaths**Reviews of critical injuries and deaths*

**11 (1)** After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for a review under subsection (3).

**(2)** For the purposes of subsection (1), the public body may compile the information relating to one or more critical injuries or deaths and provide that information to the representative in time intervals agreed to between the public body and the representative.

**(3)** The representative may conduct a review for the following purposes:

- (a) to determine whether to investigate a critical injury or death under section 12;
- (b) to identify and analyze recurring circumstances or trends
  - (i) to improve the effectiveness and responsiveness of a reviewable service, or
  - (ii) to inform improvements to broader public policy initiatives.

**(4)** If, after completion of a review under subsection (3), the representative decides not to conduct an investigation under section 12, the representative may disclose the results of the review to the public body, or the director, responsible for the provision of the reviewable service that is the subject of the review.

*Investigations of critical injuries and deaths*

**12 (1)** The representative may investigate the critical injury or death of a child if, after the completion of a review of the critical injury or death of the child under section 11, the representative determines that

- (a) a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and
- (b) the critical injury or death
  - (i) was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the Child, Family and Community Service Act,
  - (ii) occurred, in the opinion of the representative, in unusual or suspicious circumstances, or
  - (iii) was, or may have been, self-inflicted or inflicted by another person.

**(2)** The standing committee may refer to the representative for investigation the critical injury or death of a child.

**(3)** After receiving a referral under subsection (2), the representative

- (a) may investigate the critical injury or death of the child, and

(b) if the representative decides not to investigate, must provide to the standing committee a report of the reasons the representative did not investigate.

**(4)** If the representative decides to investigate the critical injury or death of a child under this section, the representative must notify

- (a) the public body, or the director, responsible for the provision of the reviewable service, or for the policies or practices, that may have contributed to the critical injury or death, and
- (b) any other person the representative considers appropriate to notify in the circumstances.

*Jurisdiction of representative in investigations*

**13** Despite section 12, this Act does not authorize the representative to investigate the critical injury or death of a child

- (a) until the completion of a criminal investigation and criminal court proceedings respecting the critical injury or death of the child,
- (b) if a coroner investigates the death of the child, until the earlier of
  - (i) the date on which a coroner has
    - (A) reported to the chief coroner under section 15 or 16 of the Coroners Act, and
    - (B) the chief coroner indicates to the coroner, under section 44 (1) (b) of the Coroners Act, that the chief coroner has no further directions in respect of the death,
  - (ii) the date on which a coroner sends, under section 22 (2) of the Coroners Act, notice of an inquest to a sheriff, directing the sheriff to summon a jury for that purpose, and
  - (iii) one year after the death, and
- (c) if a public body, or a director, responsible for the provision of a reviewable service has, at the time of the critical injury or death of the child, written procedures in place for investigating critical injuries or deaths and the public body or director investigates the critical injury or death of the child, until the earliest of
  - (i) the completion of the investigation,
  - (ii) one year after the critical injury or death of the child, and
  - (iii) the date the public body or director provides the representative with a written consent to investigate the critical injury or death of the child.

*Power to compel persons to answer questions and order disclosure*

**14 (1)** For the purposes of an investigation under this Part, the representative may make an order requiring a person to do either or both of the following:

- (a) attend, in person or by electronic means, before the representative to answer questions on oath or affirmation, or in any other manner;
- (b) produce for the representative a record or thing in the person's possession or control.

**(2)** The representative may apply to the Supreme Court for an order

- (a) directing a person to comply with an order made under subsection (1), or
- (b) directing any officers and governing members of a person to cause the person to comply with an order made under subsection (1).

*Contempt proceeding for uncooperative person*

**14.1** The failure or refusal of a person subject to an order under section 14 to do any of the following makes the person, on application to the Supreme Court by the representative, liable to be committed for contempt as if in breach of an order or judgment of the Supreme Court:

- (a) attend before the representative;
- (b) take an oath or make an affirmation;
- (c) answer questions;
- (d) produce records or things in the person's possession or control.

*Multidisciplinary team*

**15** In accordance with the regulations, the representative may establish and appoint the members of a multidisciplinary team to provide advice and guidance to the representative respecting the reviews and investigations of critical injuries and deaths of children conducted under this Part.

*Consultation, disclosure and recommendations*

**15.1 (1)** At any time during or after an investigation under section 12, the representative may consult with a public body, director or person the representative considers appropriate in relation to the critical injury or death of the child.

**(2)** If during an investigation under section 12 the representative receives a request for consultation from a public body or director, the representative must consult with the public body or director in relation to the critical injury or death of the child.

**(3)** If consulting with a public body, director or person under this section, the representative may

- (a) disclose to the public body, director or person the personal information the representative considers necessary and appropriate, and
- (b) make recommendations to the public body or director, or to another public body or director, to improve the effectiveness and responsiveness of a reviewable service.

*Reports after reviews and investigations*

**16 (1)** The representative may aggregate and analyze the information received from the reviews and investigations conducted under sections 11 and 12 and produce a report of the aggregated and analyzed information that does not contain information in individually identifiable form.

**(2)** The representative must provide a report made under subsection (1) to the following:

- (a) the standing committee;
- (b) the public body, or the director, responsible for the provision of a reviewable service that is a subject of the report;
- (c) any other public body, director or person that the representative considers appropriate.



**(3)** After an investigation of the critical injury or death of a child under section 12, the representative must make a report on the individual critical injury or death of the child.

**(4)** A report made under subsection (3) must contain the representative's reasons for undertaking the investigation and may contain the following:

- (a) recommendations for
  - (i) the public body, or the director, responsible for the provision of a reviewable service that is a subject of the report, or
  - (ii) any other public body, director or person that the representative considers appropriate;
- (b) personal information, if, in the opinion of the representative,
  - (i) the disclosure is necessary to support the findings and recommendations contained in the report, and
  - (ii) the public interest in the disclosure outweighs the privacy interests of the individual whose personal information is disclosed in the report;
- (c) any other matters the representative considers relevant.

**(5)** A report made under subsection (3) may be provided to any person that the representative considers appropriate and must be provided to

- (a) the standing committee,
- (b) the public body, or the director, responsible for the provision of a reviewable service that is a subject of the report, and
- (c) the public body, or the director, that is a subject of recommendations in the report, if not already provided the report under paragraph (b).

**Manitoba, The Children's Advocate Act** (<https://web2.gov.mb.ca/bills/40-4/b025e.php>)

*Review of services after death of child*

**22(1)** After the death of a child who was in the care of, or received services from, an agency within one year before the death, or whose parent or guardian received services from an agency within one year before the death, the children's advocate

- (a) must review the standards and quality of care and services provided under The Child and Family Services Act to the child or to the child's parent or guardian and any circumstances surrounding the death that relate to the standards or quality of the care and services;
- (b) may review the standards and quality of any other publicly funded social services that were provided to the child or, in the opinion of the children's advocate, should have been provided;
- (c) may review the standards and quality of any publicly funded mental health or addiction treatment services that were provided to the child or, in the opinion of the children's advocate, should have been provided; and
- (d) may recommend changes to the standards, policies or practices relating to the services mentioned in clauses (a) to (c) if, in the opinion of the children's advocate, those changes are designed to enhance the safety and well-being of children and reduce the likelihood of a death occurring in similar circumstances.

*Purpose of review*

**22(2)** The purpose of the review is to identify ways in which the services under review may be improved to enhance the safety and well-being of children and to prevent deaths in similar circumstances.

*Pending criminal investigation into child's death*

**22(3)** If a criminal investigation is pending into a child's death, the children's advocate must, before proceeding with the review, contact the law enforcement agency in charge of the investigation to determine whether the review may jeopardize the criminal investigation.

*Information from chief medical examiner*

**22(4)** The information provided to the children's advocate by the chief medical examiner under subsection 10(2) of The Fatality Inquiries Act may be used for the purpose of the review and report under this section, but the information must not be disclosed except as necessary to support the findings and recommendations made by the children's advocate in that report, or in accordance with subsection (7).

*Report of findings and recommendations*

**22(5)** Upon completing the review, the children's advocate must prepare a written report of his or her findings and recommendations and provide a copy to the following:

- (a) the minister;
- (b) the Ombudsman;
- (c) the chief medical examiner under The Fatality Inquiries Act;
- (d) the director;
- (e) an agency referred to in subsection (1);
- (f) the mandating authority of an agency referred to in clause (e).

*Children's advocate not to determine culpability*

**22(6)** The report must not express an opinion on, or make a determination with respect to, culpability in such a manner that a person is or could be identified as a culpable party in relation to the death of the child.

*Report is confidential*

**22(7)** The report is confidential and must not be disclosed except as required by subsection (5). But the children's advocate may disclose information from the report in a special report or annual report, in accordance with section 35.

*Independent review in case of conflict*

**22(8)** If services provided by the children's advocate come within the scope of a review under this section, the children's advocate must arrange for that part of the review to be conducted and reported on by an independent person qualified to conduct that review. Subsections (5) to (7) and section 16.1 of The Ombudsman Act apply with necessary changes to that report.

*No effect on Fatality Inquiries Act*

**22(9)** Nothing in this section limits the power or responsibility of any person under The Fatality Inquiries Act.

**New Brunswick, Child and Youth Advocate Act** (<http://www.gnb.ca/legis/bill/file/56/1/bill-74-e.htm>)

\*No mention is made of child deaths, but the following are the listed powers and duties of the Advocate.

*Powers and duties of the Advocate*

**13(1)** In carrying out the functions and duties of the office of Advocate, the Advocate may do any of the following on petition to the Advocate or on his or her own initiative:

- (a) receive and review a matter relating to a child, youth or group of children or youths;
- (b) advocate, mediate or use another dispute resolution process on behalf of a child, youth or group of children or youths;
- (c) if advocacy, mediation or other dispute resolution process has not resulted in an outcome the Advocate considers satisfactory, conduct an investigation on behalf of the child, youth or group of children or youths;
- (d) initiate and participate in, or assist a child or youth to initiate and participate in, a case conference, administrative review, mediation or other process in which decisions are made about the provision of services;
- (e) inform the public about the needs and rights of children and youths, including information about the Office of the Child and Youth Advocate; and
- (f) make recommendations to the government or an authority about legislation, policies and practices respecting services to or the rights of children and youths.

**Newfoundland, Child and Youth Advocate Act**

(<http://www.assembly.nl.ca/legislation/sr/statutes/c12-01.htm>)

*Powers and duties of the advocate*

**15. (1)** In carrying out the duties of his or her office, the advocate may

- (a) receive, review and investigate a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the advocate;
- (b) advocate or mediate or use another dispute resolution process on behalf of a child, youth or a group of them, whether or not a request or complaint is made to the advocate;
- (c) where advocacy or mediation or another dispute resolution process has not resulted in an outcome the advocate believes is satisfactory, conduct an investigation on behalf of the child or youth or a group of them, whether or not a request or complaint is made to the advocate;
- (d) initiate and participate in, or assist children and youth to initiate and participate in, case conferences, administrative reviews, mediations, or other processes in which decisions are made about the provision of services;
- (e) meet with and interview children and youth;

- (f) inform the public about the needs and rights of children and youth including about the office of the advocate; and
- (g) make recommendations to the government, an agency of the government or communities about legislation, policies and practices respecting services to or the rights of children and youth.

#### *Restriction on jurisdiction*

**15.1** Nothing in this Act authorizes the advocate to investigate

- (d) a matter which is the subject of a review by the Child Death Review Committee under the authority of section 13.2 of the Fatalities Investigations Act; or
- (e) a matter which is the subject of a public inquiry under the authority of section 26 of the Fatalities Investigations Act until that public inquiry has been completed.

#### **Northwest Territories**

The Northwest Territories does not have Child and Youth Advocate.

#### **Nova Scotia, Child and Youth Advocate Act**

([http://nslegislature.ca/legc/bills/61st\\_4th/1st\\_read/b080.htm](http://nslegislature.ca/legc/bills/61st_4th/1st_read/b080.htm))

\*No mention is made of child deaths, but the Act does state:

**11** The Child and Youth Advocate shall exercise both advocacy and investigative functions.

#### **Nunavut, Representative for Children and Youth Act**

(<http://rcynu.ca/sites/rcynu.ca/files/RCY%20Act%20English.pdf>)

##### *Powers*

- 4. (1)** In addition to any other powers under this or any other Act, the Representative for the purpose of performing his or her duties may
- (b) review any matter related to the death or critical injury of any child or youth;

##### *Death or Critical Injury of a Child or Youth*

##### *Duty of Director of Child and Family Services to report death or critical injury*

**19. (1)** The Director of Child and Family Services appointed under the Child and Family Services Act shall report to the Representative the death or critical injury of a child or youth if, at the time of the death or injury or within one year before the death or injury,

- (a) the child or youth was in the temporary or permanent custody of, or was receiving services from, the Director;
- (b) a parent having care of the child or youth was receiving services from the Director; or
- (c) an individual having care of the child or youth was receiving services from the Director.

*Time of report*

**(2)** The Director shall make a report required by subsection (1) as soon as is reasonably possible after learning of the death or injury of the child or youth and of the existence of a circumstance set out in paragraph (1)(a), (b) or (c).

*Duty of coroner to report death*

**20.** A coroner shall report the death of a child or youth to the Representative as soon as is reasonably possible after learning of the death if it is reportable under section 8 of the Coroners Act.

*Duty of coroner to provide information*

**21.** A coroner who conducts an investigation of the death of a child or youth under the Coroners Act shall, as soon as is reasonably possible, inform a parent of the child or youth, or a person having care of the child or youth at the time of the death, of the existence and role of the Representative and how the Representative may be contacted.

*Annual report*

**35. (1)** The Representative shall, within six months after the end of each fiscal year, prepare and submit to the Speaker of the Legislative Assembly an annual report on the conduct of the office and the discharge of the duties of the Representative during the preceding year, including

(c) summaries or descriptions of any reviews related to a child or youth or a group of children or youth, or to the death or critical injury of a child or youth, and any advice or recommendations resulting from the reviews;

**Ontario, Provincial Advocate for Children and Youth Act**

(<https://www.ontario.ca/laws/statute/07p09>)

*Matters excluded from investigation*

**16.4 (1)** The Advocate is prohibited from investigating any of the following matters:

1. Subject to subsection (2), child deaths that fall within the jurisdiction of the Office of the Chief Coroner or of any committees that report to the Office of Chief Coroner.

Note: On June 10, 2016, the Act is amended by adding the following section:

*Death or serious bodily harm*

**18.1 (1)** An agency or service provider, as the case may be, shall inform the Advocate in writing and without unreasonable delay after it becomes aware of the death of or serious bodily harm incurred by a child or youth, where the child or youth, or the child or youth's family, has sought or received a children's aid society service within 12 months of the death or incurrance of harm.

*Provision of information to the Advocate*

**(2)** Information provided to the Advocate under subsection (1) shall include a summary of the circumstances surrounding the death or serious bodily harm.

*Duty to report under the Child and Family Services Act*

**(3)** Nothing in this section affects the duty to report a suspicion under section 72 of the Child and Family Services Act.

*Provision of information to parents*

**(4)** An agency or service provider, as the case may be, shall inform the parents of a child that has died or suffered serious bodily harm in the circumstances described in subsection (1) about the Advocate and shall provide the parents with contact information for the Advocate.

*Provision of information to a child*

**(5)** An agency or service provider, as the case may be, shall inform a child that has suffered serious bodily harm in the circumstances described in subsection (1) about the Advocate and shall provide the child with contact information for the Advocate.

**Prince Edward Island**

Prince Edward Island does not currently have a Child and Youth Advocate. The Opposition Government has been calling for one in recent months.

**Saskatchewan, The Advocate for Children and Youth Act**

(<http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/a5-4.pdf>)

\*No mention is made of child deaths, but the following are the listed powers and duties of the Advocate.

*Powers and duties of Advocate*

**14(1)** The Advocate has the power to do all things necessary to perform the duties given to the Advocate pursuant to this Act.

**(2)** The Advocate shall:

- (a) become involved in public education and advocacy respecting the interests and well-being of children and youths;
- (b) receive and investigate any matter that comes to his or her attention from any source concerning:
  - (i) a child or youth who receives services from any ministry, agency of the government or publicly-funded health entity;
  - (ii) a group of children or youths who receive services from any ministry, agency of the government or publicly-funded health entity; and
  - (iii) services to a child, group of children, youth or group of youths by any ministry, agency of the government or publicly-funded health entity;
- (c) if appropriate, try to resolve those matters mentioned in clause (b) through the use of negotiation, conciliation, mediation or other non-adversarial approaches; and
- (d) if appropriate, make recommendations on any matter mentioned in clause (b).

**(3)** The Advocate may:

- (a) conduct or contract for research to improve the rights, interests and well-being of children or youths;
- (b) advise or make recommendations to any minister responsible for services to children or youths on any matter relating to the interests and well-being of children or youths who receive services from any ministry, agency of the government or publicly-funded health entity.

**Yukon, Child and Youth Advocate Act** ([http://www.gov.yk.ca/legislation/acts/chyoad\\_c.pdf](http://www.gov.yk.ca/legislation/acts/chyoad_c.pdf))*Definitions***1** In this Act

“designated services” means programs or services for children or youth provided

- (a) directly by a department, including schools under the jurisdiction of the Minister of Education,
- (b) as part of a school by a school board established under the Education Act, and
- (c) by a First Nation service authority designated under section 169 [designation of First Nation service authority] of the Child and Family Services Act following the coming into force of that section

*Referral by Legislative Assembly or Minister*

**15(1)** The Legislative Assembly or a Minister may refer to the Advocate for review and report any matter relating to the provision of designated services that involves the interests and well-being of children and youth, which may include a review of critical injuries, a death or other specific incident concerning a child or youth in the care or custody of the government or a First Nation service authority.

**(2)** The Advocate must conduct a review and make a report under subsection (1) in accordance with the terms of reference established for the review by the Legislative Assembly or the Minister.