Office of the Chief Coroner
Province of Ontario

Paediatric Death Review Committee – Medical and Child and Youth Death Review and Analysis

Report for 2019-2021

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Introduction

Ontario's death investigation system is the largest in North America. In Ontario, coroners are medical doctors with training in the principles of death investigation. Coroners investigate deaths in accordance with Section 10 of the *Coroners Act*. In 2021, the Office of the Chief Coroner (OCC) investigated approximately 16% of all deaths that occurred within the province. The OCC investigates deaths involving non-natural causes, e.g. injuries (both intentional and non-intentional) and those that occur that occur suddenly and unexpectedly to fully understand the circumstances of the deaths and potentially provide recommendations to prevent further deaths Investigations are also completed into deaths that occur in certain settings, e.g., correctional facilities and under such circumstances where an investigation is believed to be required.

Death investigation services are provided by the OCC and the Ontario Forensic Pathology Service (OFPS). Together, they form a division within the Ministry of the Solicitor General (SolGen). The OCC partners with the OFPS to ensure a coordinated and collaborative approach to conduct death investigations in the public interest.

The OCC applies the following definitions when determining the manner of death:

Natural: Cause of death was a disease, or a complication of its treatment. Injury did not cause or substantially contribute to the death.

Accident: Cause of death was an injury where death was not intended or foreseen. Inflicted injury did not cause or substantially contribute to the death.

Suicide: Cause of death was an injury which was non-accidentally inflicted by the deceased.

Homicide: Cause of death was an injury which was non-accidentally inflicted by a person other than the deceased.

Undetermined: Cause of death could not be selected from the classifications of Natural, Accident, Suicide and Homicide because the evidence:

i. Was inadequate e.g., skeletal remains;

ii. Was equal for two or more classifications, or so nearly equal that they could not be confidently distinguished; or

iii. Did not reasonably fit the definitions of the four classifications.

The OCC investigates approximately 43% of all child and youth deaths that occur within Ontario each year. The investigation and review of child and youth deaths is an area that continues to be one of the most important and challenging areas within the OCC's mandate. The deaths of children and youth are challenging from both emotional and investigative perspectives.

The OCC has taken several measures over the last few years to enhance child and youth death investigation and review.

The Child and Youth Death Review and Analysis (CYDRA) Unit within the OCC has been developing and transforming the processes for child and youth death reviews. The former Paediatric Death Review Committee – Child Welfare (PDRC-CW) has been replaced by several distinct death review processes. The PDRC-CW was a standing committee specific to the child welfare sector, limited to reviewing the deaths of young people involved with the child welfare system within the 12 months preceding their death. The current review structures are designed to evolve through collaborative transformation, which is why the word 'interim' is used for some of the current review processes.

The purpose of child and youth death reviews is to explore the circumstances related to the child or youth's death in order to honour their lives, learn from them, and make recommendations that may enhance the overall well-being of young people and contribute to the prevention of further deaths.

Under CYDRA, the type of review is informed by the circumstances of the death and the specific issues to be explored. Currently, the review processes that are in place under CYDRA include:

- Local Death Review Tables are an intersectoral approach to death review in which individuals who worked directly with the child/youth are brought together in addition to individuals with specialized knowledge specifically relevant to the death to review the journey of the deceased child or youth.

- Two interim Paediatric Death Review Committees for Children and Youth (PDRC-CY), one for review of deaths of Indigenous children and youth and the other for non-Indigenous children and youth. These death review processes are <u>not</u> limited to child welfare-specific deaths and may include deaths where other systems, such as education and youth justice, are involved.

- Expert reviews by subject matter experts will evaluate specific issues identified during the initial death investigation and review.

- Local Reviews co-developed through First Nation led Protocols. As a part of the collaborative transformation, CYDRA is working with First Nations (where invited) to develop local protocols for Indigenous child and youth death reviews.

The new processes look beyond the child welfare system and include deaths that may be referred to CYDRA by the local coroners or Regional Supervising Coroners, the Office of the Ombudsman of Ontario, the Ministry of Children, Community and Social Services (MCCSS), or other child and youth serving systems, such as the education system. For this reason, each death reported and/or referred to CYDRA is reviewed on an individual basis to inform potential further review and recommendations.

It is recognized that the factors that influence a person's journey are not isolated to the immediate circumstances surrounding their death. Children and youth intersect with various systems throughout the course of their lives, and those systems may influence the specific

circumstances that contributed to the death of the child or youth. Consequently, an effective death review process requires integrated data regarding the circumstances of a person's death *and* their intersections with systems. An intersectional analysis of this data is the key to targeting further analyses, prevention strategies and areas where future research could be of benefit.

The following principles underpin the work of CYDRA:

- **Intersectional approach:** Social identity is complex and multifaceted, and several social factors intersect to determine social location of an individual. Therefore, it is important to collectively analyze the factors that affect individuals' lives rather than considering them in isolation. Systems and structures are underpinned by colonialism and racism which can produce distinct experiences, especially for Indigenous and racialized populations.

- **Colonialism is real and ongoing:** First Nations, Inuit and Métis children and youth have been, and continue to be, overrepresented within the child welfare system. These children and youth are disproportionally impacted by racism and colonization, which are manifested in policies and actions such as the Sixties Scoop, Indian Residential School System, and the ongoing Millennial Scoop. Understanding the role of racism and the harmful impacts that it continues to have is critical to preventing further deaths.

- **Anti-Black racism is real:** Black children, youth and families are overrepresented in child welfare and other youth-serving systems, and as a result, they experience barriers, oppression and disparities within those systems as a function of systemic racism.

- **Trauma is complex:** Understanding how trauma manifests in life choices and outcomes is critical to understanding young people and their journeys.

Recognizing that death prevention is a shared responsibility, and that children, youth, families, and communities are impacted by multiple systems, the death review processes aim to understand how these systems impact lived experiences and incorporate multiple organizations at various levels to inform the death investigation and review process. With broader input and participation, there will be increased opportunity for timely, relevant learning for all involved. Similarly, comprehensive data will be available to inform prevention and identify trends and themes that can point to systemic issues. CYDRA is supported by a specific policy directive between the OCC and the Ministry of Children, Community and Social Services (formerly Ministry of Children and Youth Services). The 2006 Joint Directive on Child Death Reporting and Review[1] outlines the process that Children's Aid Societies and Child and Family Well-being Agencies must follow when reporting and reviewing child and youth deaths when they have been involved with the child, youth or family within 12 months of the death.

[1] This directive is issued under section 20.1 of the Child and Family Services Act and replaces the October 1, 2000 joint directive on child death reporting and review

Historically, the process for reporting child and youth deaths to the OCC has been through the Joint Directive. However, it is recognized that further work is needed to collaborate on an enhanced reporting mechanism to include the reporting of deaths not covered under the 2006 Joint Directive, so that the policy better aligns with the transformation work being undertaken at CYDRA. While the 2006 Joint Directive is still in place, deaths with no child welfare involvement but where potential systems issues are identified can be referred to CYDRA in a variety of ways, as mentioned above (e.g., those recommended by the coroners, First Nations, Ombudsman Office, and Ministries).

This Annual Report will centre the analysis and findings of the data collected by the OCC for children and youth who died between 2019-2021, inclusive.

Office of the Chief Coroner and the Context of Child and Youth Deaths in Ontario

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

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

While the OCC defines the paediatric age group from live birth to the nineteenth birthday, CYDRA reviews the deaths of youth up to 23 years of age. This is consistent with Policy Directive CW 003-23 which has effectively increased the age limit for youth that receive continued care and support from Children's Aid Societies or Child and Family Well-being Agencies.

Chart 1: Comparison of Child and Youth Deaths in Canada and Ontario with Ontario Coroner Investigations (age 0-19 years, 2010-2021)

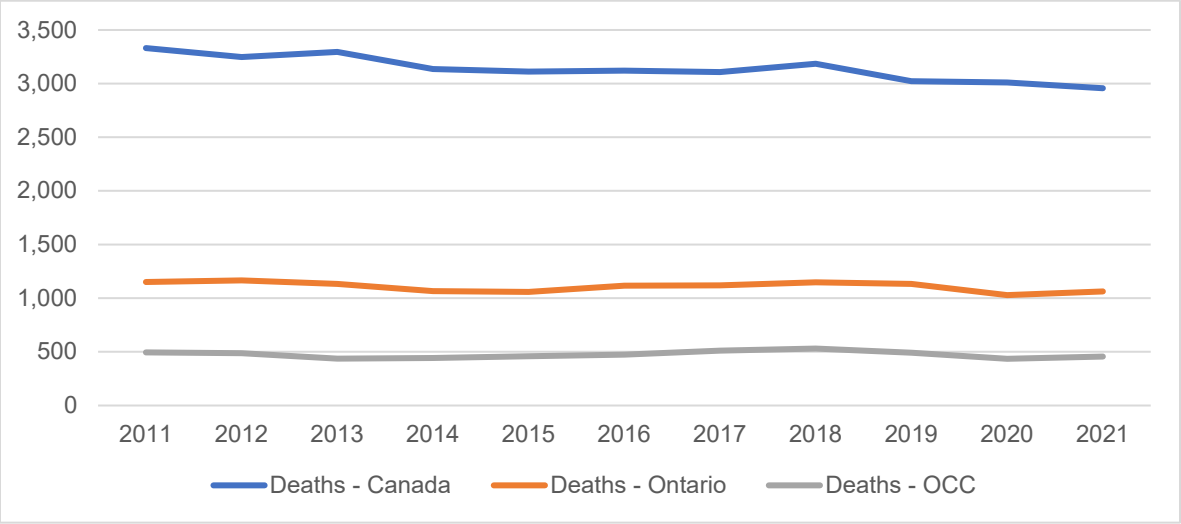


Chart 1 illustrates the number of child and youth deaths per year and compares the number of deaths investigated by the OCC with the provincial and national numbers. Between 2010 and 2021, the year-to-year totals have remained relatively consistent.

Chart 2: Child And Youth Population Vs Deaths In Ontario Compared With Canadian Totals (Age 0-19, 2010-2021)

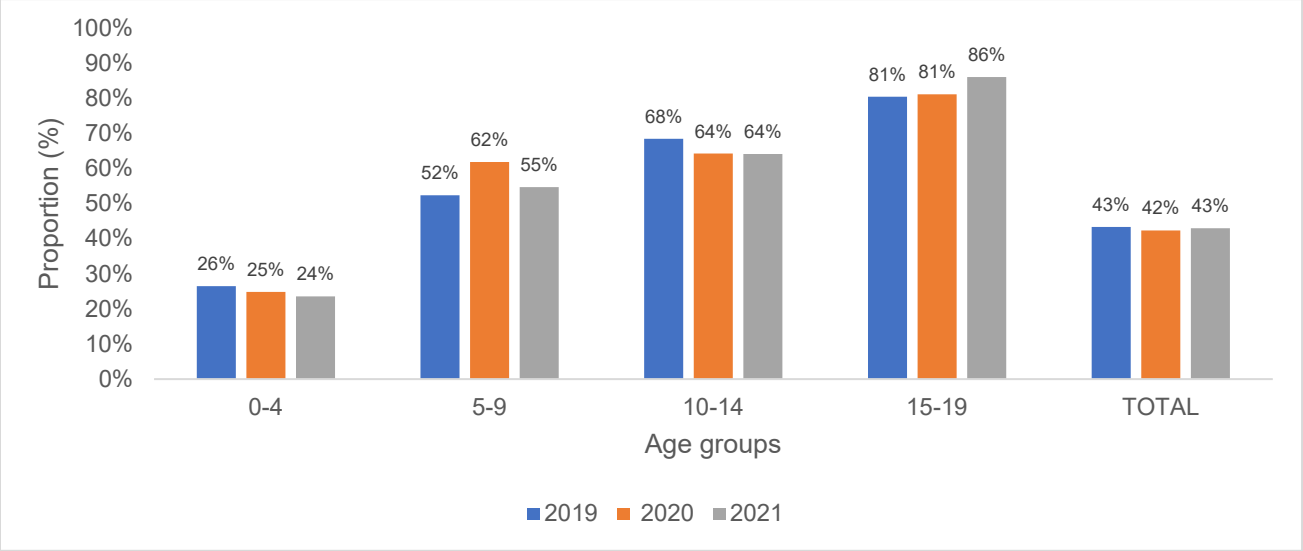
	Children and youth population			Children and youth deaths		
Year	**Ontario**	**Canada**	**% of Ontario populations vs Canada**	**Ontario**	**Canada**	**% of Ontario deaths vs Canada**
2010	3,107,458	7,871,049	39%	1,201	3,424	35%
2011	3,102,449	7,865,018	39%	1,151	3,331	35%
2012	3,089,543	7,857,935	39%	1,166	3,247	36%
2013	3,078,716	7,858,925	39%	1,132	3,295	34%
2014	3,070,164	7,870,897	39%	1,066	3,135	34%
2015	3,062,245	7,886,794	39%	1,058	3,112	34%
2016	3,079,434	7,949,667	39%	1,116	3,120	36%
2017	3,095,381	8,002,681	39%	1,119	3,107	36%
2018	3,119,061	8,072,580	39%	1,147	3,179	36%
2019	3,131,045	8,122,020	39%	1,132	3,018	38%
2020	3,130,254	8,139,158	38%	1,029	3,010	34%
2021	3,094,198	8,078,797	38%	1,062	2,957	36%

Chart 2 provides the actual number of child and youth deaths per year and shows the percentage of deaths in Ontario as a proportion of the national total. Between 2010 and 2021, the year-to-year totals have remained fairly consistent. From 2019 to 2020, there was a slight decrease in the proportion of deaths in Ontario in comparison to the national total, however it increased again in 2021.

Chart 3: Distribution of Child And Youth Deaths Across Age Groups, 2019-2021

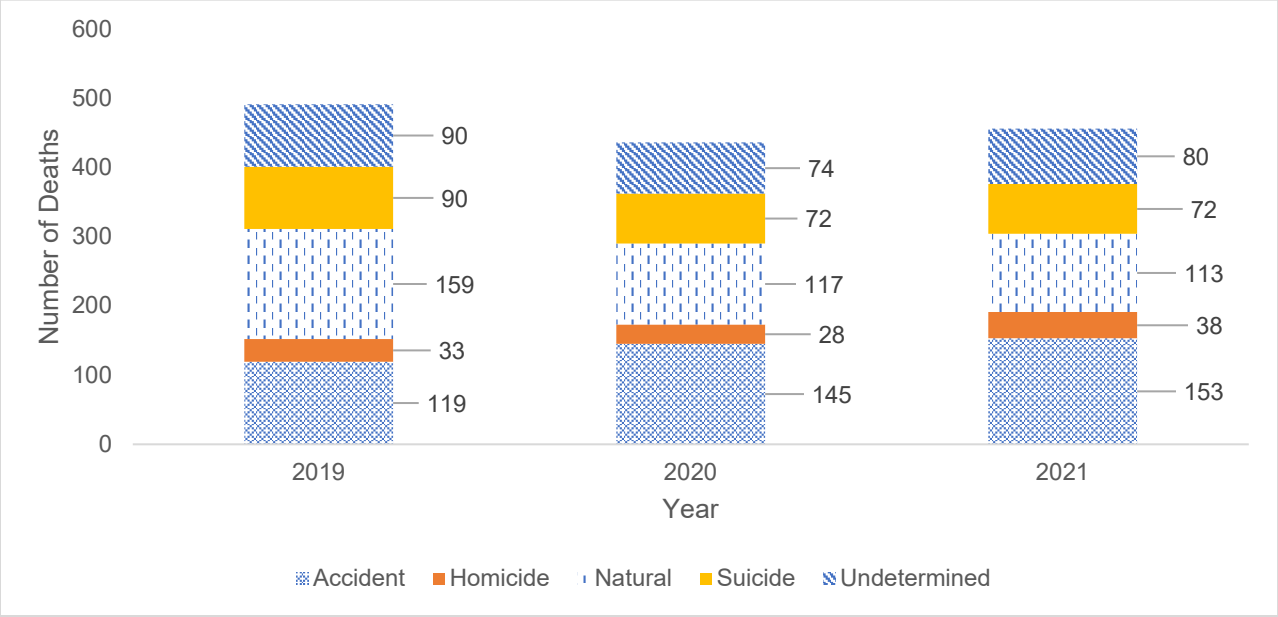
	2019			2020			2021		
Age group	**Ontario deaths**	**OCC deaths**	**Proportion of deaths investigated by coroner**	**Ontario deaths**	**OCC deaths**	**Proportion of deaths investigated by coroner**	**Ontario deaths**	**OCC deaths**	**Proportion of deaths investigated by coroner**
0-4	729	193	26%	669	166	25%	683	161	24%
5-9	63	33	52%	42	26	62%	53	29	55%
10-14	73	50	68%	84	54	64%	67	43	64%
15-19	267	215	81%	234	190	81%	259	223	86%
TOTAL	**1,132**	**491**	**43%**	**1,029**	**436**	**42%**	**1,062**	**456**	**43%**

Chart 3.1: Proportion of Ontario Deaths Investigation by the OCC Across Age Groups, 2019-2021



Charts 3 and 3.1 illustrate that between 2019 and 2021, approximately 43% of all child and youth deaths in Ontario were investigated by the OCC. When broken down by age groups, the proportion of deaths investigated increases as the age of the young people increase. For example, for all three years the OCC investigated less than 26% of all deaths for children between the age of 0 and 4 years, whereas, more than 80% of deaths were investigated for youth between the age of 15 and 19 years.

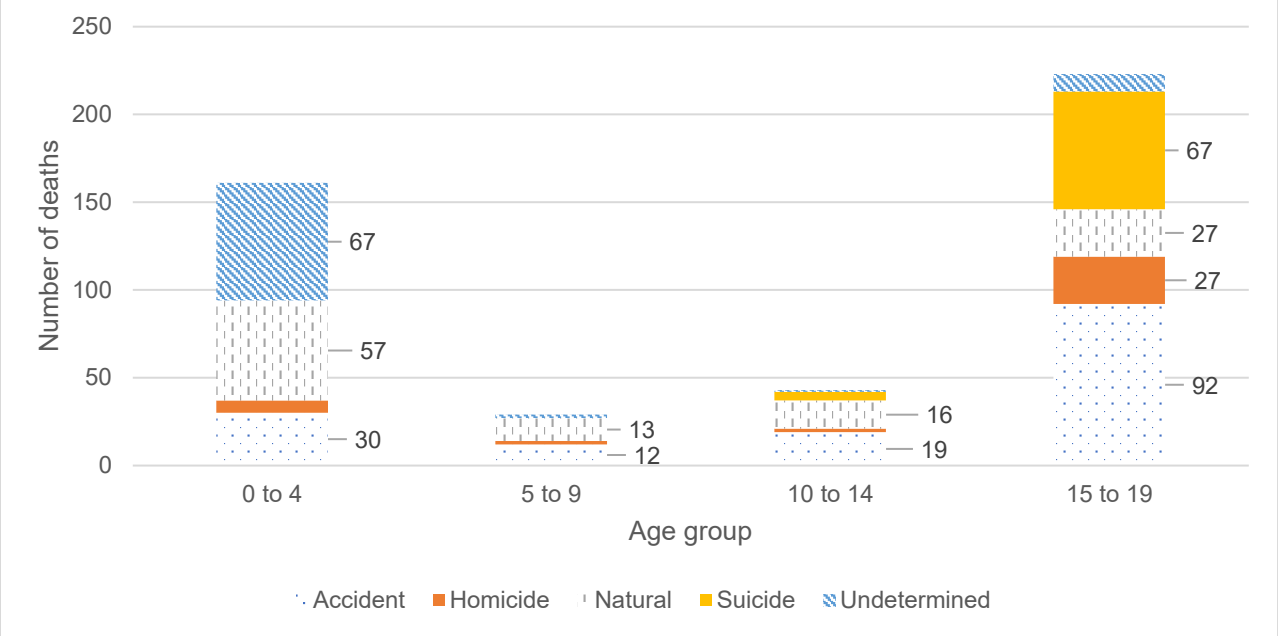
Chart 4: Manner of Death in OCC investigations, ages 0-19, 2019-2021*



*Please note that approximately 2% of the manner of deaths reported for 2021 are preliminary and may change in future reports.

In 2019, natural deaths were most common deaths investigated by the OCC, followed by accident. However, in the following two years, accident was the most common manner of death, followed by natural deaths. Across all the three years, homicide was the least common manner of death.

Chart 4.1: Manner of Death in OCC investigations – Distribution Across Age Groups (2021)



The highest number of children between the age of 0 and 4 years died of undetermined causes, followed by natural deaths. For children between the ages of 5 and 14 years, natural and accident were the most common manners of death. For youth between the ages of 15 and 19 years, accident was the most common manner of death, followed by suicide.

Accidental deaths

Chart 4.2: Most common death factors for accidental deaths in 2021

Death factor	Percent of total accidental deaths
Acute Drug toxicity	29%
Trauma - Motor Vehicle Collision	27%
Drowning – Lakes, Ponds, Rivers et cetera	5%

In 2021, there were 153 deaths where the manner of death was classfied as accident. The most common cause of death was acute drug toxicity which accounted for 29% of all accidental deaths investigated by the OCC. Most of the deaths from acute drug toxicity occurred among youth between the ages of 15 and 19 years. The second most common death factor was trauma as a result of motor vehicle collision, which accounted for 27% of all accidental deaths investigated by the OCC.

Paediatric Death Review Committee – Medical

Overview

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

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

Review process

Case assignment occurs by aligning the practice profile and expertise of the committee members with the circumstances of the death. For example, paediatric deaths from a community setting will be reviewed by one of the community paediatricians. The review process involves analyzing the existing record of the young person. The record routinely includes medical records, the Coroner's Investigation Statement, the report of the post-mortem examination, toxicology report, police report and other relevant documents.

At the committee meetings, the primary reviewer presents the findings to the members for discussion. This provides an opportunity for discussion about issues that may have been identified through the review. The committee may develop recommendations based on the findings of the review. The primary reviewer will compose a final report reflecting the committee's consensus opinion. The report, which will include the cause and manner of death and any committee recommendations, is provided to the referring Regional Supervising Coroner. If the recommendations are systemic, the ministry, organization, agency, or individuals are notified by the Committee Chair. Since 2017, organizations have been asked to respond within six months of receiving the recommendations, which is consistent with the OCC's approach to inquest recommendations.

Where a death review presents a potential or real conflict of interest for a committee member, that member does not participate in the review process.

Limitations

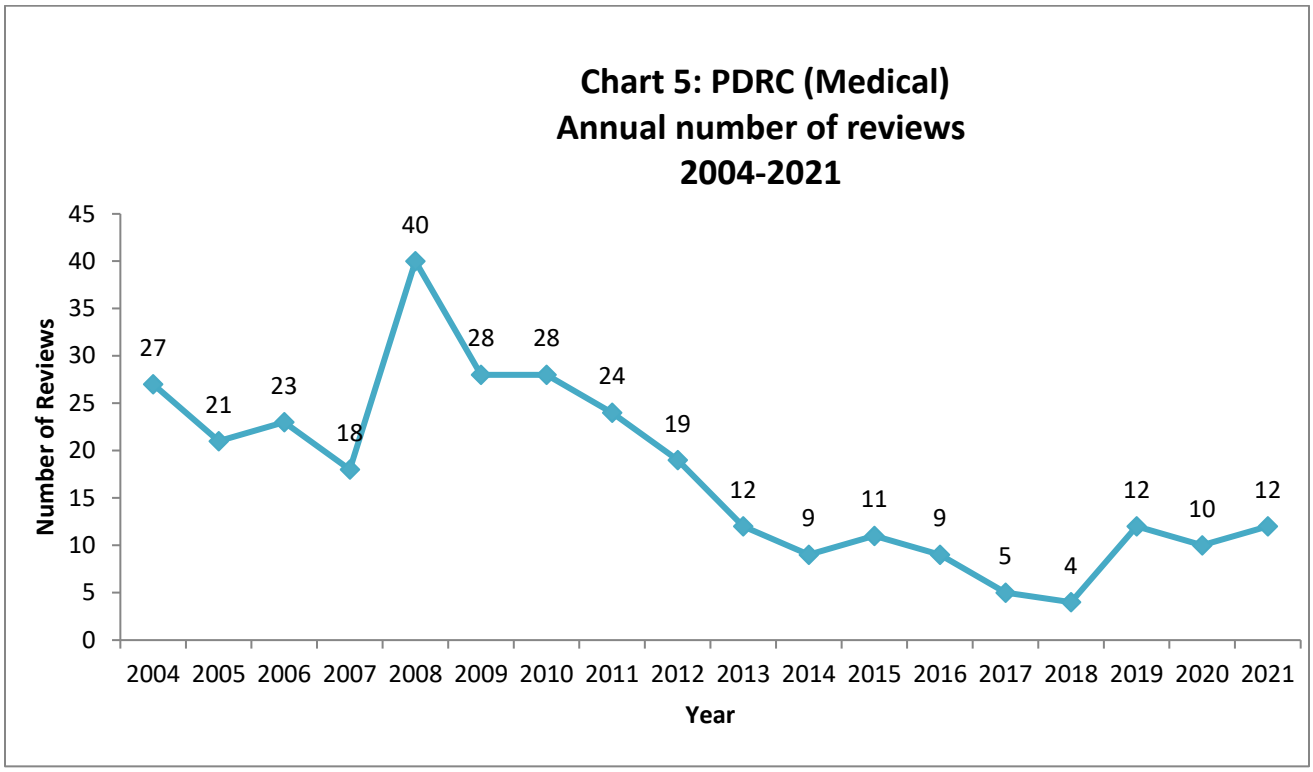
The PDRC-Medical death reports are prepared for the OCC and are governed by the *Coroners Act, the Vital Statistics Act, the Freedom of Information and Protection of Privacy Act and the Personal Health Information and Protection of Privacy Act.*

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

It is pertinent to note that recommendations are made following a careful review of the circumstances of each death; they are not intended to be policy directives.

Analysis

The number of PDRC-Medial reviews varies from year to year. Chart 5 illustrates the number of PDRC- Medical review from 2004 to 2021. In 2019, 2020 and 2021, 12, 10 and 12 reviews were conducted respectively.



Recommendations

One of the goals of PDRC – Medical review is informing medical systems through recommendations using a "no blame" approach. The focus is on preventing further deaths via:

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

In 2019, nine of twelve reviews resulted in thirteen recommendations. There were three reviews that resulted in no recommendations.

In 2020, nine of ten reviews resulted in fifteen recommendations. One death review that resulted in no recommendations.

In 2021, eleven of twelve reviews resulted in twenty-four recommendations. One review that resulted in no recommendations.

Summary of recommendations made by PDRC – Medical

The recommendations made from the PDRC – Medical reviews in 2019-2021 focused on the following themes and were directed to the identified organizations:

Organization(s) asked to respond to recommendation	Theme of recommendation(s)	Number of reviews where theme was identified 2019 -2021
Treating Healthcare Professional Healthcare Organization Critical Care Services Ontario OCC Regional Office Provincial Council for Maternal and Child Health Professional Association Healthcare Professional Regulatory Body	Quality of Care	19
Healthcare Organization Police Agency Local Child Welfare Agency Professional Association Healthcare Regulatory Body Death Investigation System Provincial Council for Maternal and Child Health Healthcare Association Critical Care Services Ontario Health Canada	Policy and Procedure	8
Healthcare Organization Police Agency Local Child Welfare Agency OCC Regional Office Provincial Council for Maternal and Child Health Critical Care Services Ontario Healthcare Professional Regulatory Body	Communication/ Documentation	9
OCC Regional Office Healthcare Organization	Testing	9
Provincial Council for Maternal and Child Health Treating Health Care Professionals	Transport	4
Healthcare Organization Critical Care Services Ontario Provincial Council for Maternal and Child Health Professional Associations Healthcare Professional Regulatory Body Health Canada Parachute Canada	Education/ Training	11
Provincial Council for Maternal and Child Health OCC Regional Office	Other	3

Themes arising during medical reviews

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

Themes by year or between 2019 - 2021

The cases reviewed by the PDRC – Medical in 2019-2021 were associated with six key themes. Some cases had more than one theme identified.

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

<u>Quality of Care</u>

The following treatment and/or quality of care issues were identified:

- Triaging consultations
- Resuscitation team dynamics
- Recognition and treatment of paediatric shock
- Standards and certification of ER staff/referral to Criticall
- Early recognition of paediatric surgical conditions necessitating urgent or emergent transfer to a referral centre
- Importance of the timely measurement of a blood glucose level in an acutely ill and/or neurologically depressed child
- Equipment preparedness protocols
- Paediatric airway management
- Recognition and management of acute abdomen in children
- Identifying findings compatible with congenital diaphragmatic hernia
- Clinical and radiologic indications for sustained in-hospital monitoring or hospital admission in infants and children with acute respiratory illnesses
- Resuscitation guidelines for infants, including choice of medications

<u>Policy and procedures</u>

- Collaboration in complex child protection cases to ensure that suspicious injuries or other concerns for maltreatment are appropriately assessed
- Acceptance of unstable surgical cases and operative and perioperative management of an unstable paediatric patient
- Cardiac assessment prior to discharging patients with complex single ventricle physiology

- Identification of related cases referred to the OCC
- Triage protocols and procedures to support rapid diagnosis and removal of button batteries, as well as follow up investigations to assess the degree of on-going injury
- Car seat standards, specifically modifications to meet the positional and transportation needs of preterm and low birthweight infants
- Engagement of Paediatric Critical Care Response Team (PCCRT) Program in life and limb situations, and early activation of Criticall

Communication and documentation

- Importance of physician orders being clearly written and accurately transcribed
- Communication and consultation with subspecialty care teams in the management of medically complex cases
- Publication of the hazards associated with button battery ingestion

Testing

- Recommendations for further cardiac evaluation and/or genetic testing of family members
- Use of ultrasound assessment of the urinary tract in patients with renal impairment to seek reversible causes
- Availability of capillary blood sampling and point of care testing

Transport

- Transport and transfer protocols and procedures of critically ill children and youth
- Adding additional trained personnel to assist with resuscitation over long transports

Education and training

- Education on safe sleeping environments and practices to all clients and caregivers
- Education on the dangers of battery ingestion in children and highlighting the potentially fatal consequences
- Maintenance of certification in paediatric advanced life support (PALS)

Other

- Recommended change(s) to cause and manner based on additional testing.
- Potential funding opportunities to assist families with ongoing medical costs that may exceed their individual financial resources

Child and Youth Death Review and Analysis

Overview

The Office of the Chief Coroner has a dedicated unit for child and youth death review and investigation, referred to as Child and Youth Death Review and Analysis (CYDRA). A primary focus of the work is to review and investigate deaths of children and youth where there was involvement with child and youth-facing service systems. This could involve interaction with child welfare, the youth justice system, children and youth mental health, or the education system.

The goal of child and youth death review is to reduce child and youth deaths, make service-level, systemic, and structural recommendations aimed to prevent deaths, and to contribute to public safety by supporting recommendations that enhance the overall well-being of children, youth, their families, and communities.

The purpose of child and youth death reviews is to explore the circumstances related to the child or youth's death in order to honour their lives, learn from them and make recommendations that may contribute to the prevention of further deaths.

Death Review Processes

Each of child and youth death reported is evaluated and considered for further review or investigation. Where it is determined that further review would be beneficial, deaths are reviewed through a process that best honors and respects the child or youth and one that will contribute to learning. CYDRA reviews information from Serious Occurrence Reports, Child Fatality Case Summary Reports, and coroner's investigation statements as part of the decision-making process. A number of other criteria are also considered, including factors based on research and best practice.

Examples of death review processes for children and youth are outlined below:

- Interim Paediatric Death Review Committee-Children and Youth (PDRC-CY) - Indigenous
- Interim Paediatric Death Review Committee - Children and Youth (PDRC-CY) – non-Indigenous
- Local Reviews co-developed through First Nation led Protocols
- Local Death Reviews Tables
- Expert Reviews
- Other Death Review Processes (e.g., case conferences)

Careful attention and thought is included in each death review, including a comprehensive review of information and working with experts and sectors to determine who best participates in the review. Each death is unique in terms of the review process depending on the individualized factors related to the young person and their experience *(For more information, see Appendix A).*

Child Welfare - Society/Agency Involvement

Child welfare services in Ontario are provided by thirteen (13) Indigenous Child and Well-being Agencies, and thirty-seven (37) Children's Aid Societies. Under the Joint Directive on Child Death Reporting and Review[2], coroners in Ontario investigate all paediatric deaths where a Society/Agency has been involved with the child, youth or family within 12 months of the death.

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

- Comparing child and youth deaths with Society/Agency involvement to deaths without Society/Agency involvement;
- Providing recommendations in an effort to prevent further deaths.

Use of data by CYDRA – Child Welfare or Indigenous Child and Family Well-being

This section of the annual report presents summary statistics to compare and observe the child and youth population in Ontario in the context of Society/Agency involvement. Descriptive statistical analyses have been utilized to support the presentation of available data. The results of the data from the years 2019-2021 are included in this report.

The data analyzed to date suggests that there is sufficient variability year-over-year to merit the ongoing examination of the data prior to drawing any conclusions. As time passes and larger data sets are developed, the ability to identify trends or draw conclusions from the data will improve. At this time, the significance of some available data is not known due to insufficient data points.

In some cases, no statistical analysis could be completed because of limitations arising from the nature of the data, the size of the populations, or challenges with data as discussed above. There are several challenges with the data available for analysis that merit consideration when reading this report.

The data is collected primarily by coroners from across the province. Limits in standardization and non-confirmation of data accuracy may affect the analysis. The OCC has developed a new data capture system, QuinC, that is expected to improve the quality and completeness of the OCC's data with implementation in 2021.

The lack of comparator data from other sources is another significant barrier to inferential and comparative analyses. Data from different sources is collected with varying sets of parameters, depending on the organization's needs. Some of the data required for effective comparison is unavailable. Other data sets are incomplete or are measured in ways that do not align with the data that the OCC and CYRDA collect.

[2] Policy work is required to update and involve other child and youth serving systems

Understanding the Role of Natural Deaths with Child Welfare Involvement and Deaths Still Under Investigation

By policy, coroners in Ontario investigate all paediatric deaths of children and youth where a Society has been involved with the child, youth or family within 12 months of the death. Consequently, some paediatric deaths that would not ordinarily meet the criteria for a coroner's investigation are investigated solely because of the involvement of a Society/Agency. These deaths include natural deaths that occurred in a hospital/hospice or that were expected to occur, which under normal circumstances would not likely be investigated by a coroner. These deaths are excluded from the analyses undertaken in this report to allow for the comparison of deaths with Society/Agency involvement against the cohort of paediatric coroners' investigations (which does not include natural deaths free of care related concerns). From 2019 to 2021, 44 child and youth deaths fell into this category and have been removed from the analysis.

Analysis

Child and youth deaths with Society/Agency involvement compared to other child and youth deaths in Ontario (2019-2021)

In 2021, there were 1,062 deaths of children and youth aged 0 – 19 (inclusive) in Ontario, of which, 456 deaths met the criteria for a coroner's investigation. Of the paediatric deaths investigated by a coroner in 2021, 101 (22%) were reported to CYDRA because of Society/Agency involvement with the child, youth, or family within 12 months prior to the death. This is consistent with the proportion of deaths investigated previously in this age group.

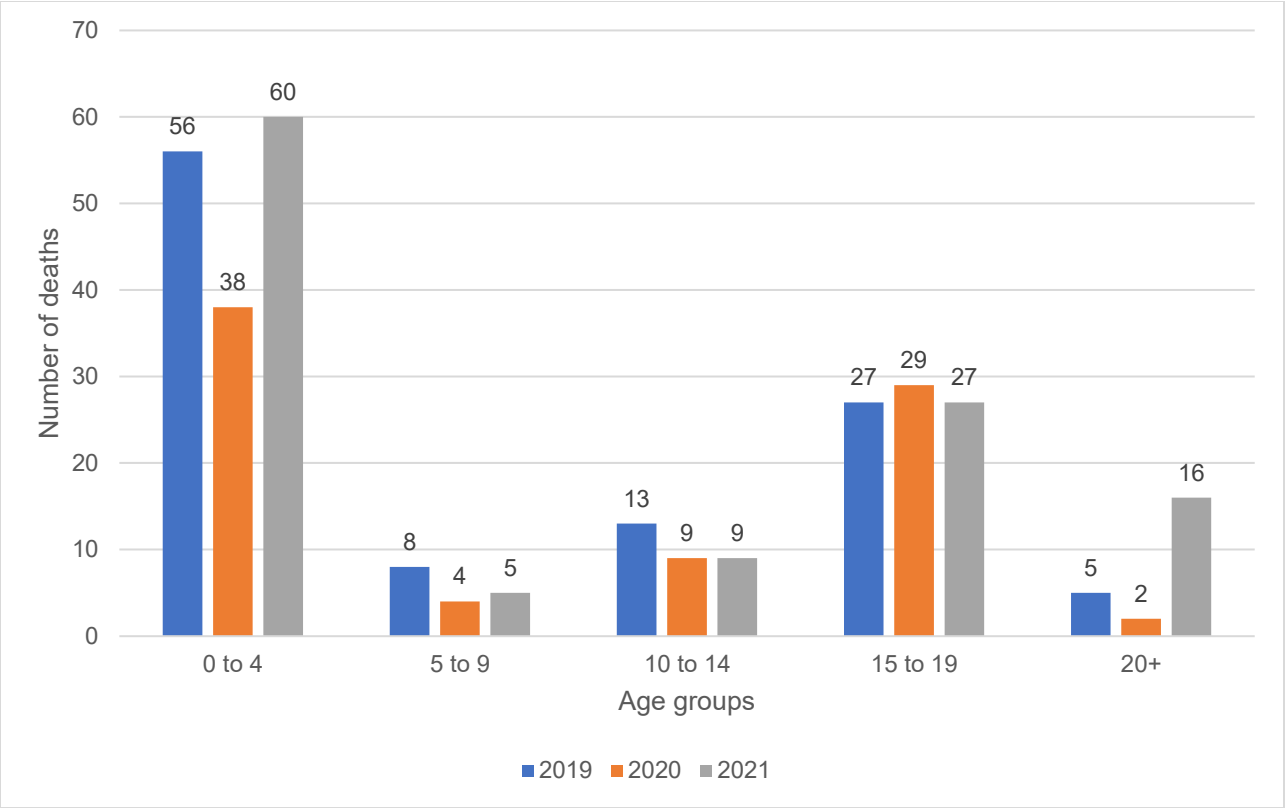
In addition to the 101 deaths reported by a Society/Agency in 2021, Societies/Agencies also reported the deaths of 16 youth (ages 20 – 22 years). As these 16 youth were receiving Continued Care and Support for Youth (CCSY) from a Society/Agency at the time of their death or case closure, they were included in this analysis (total age 0-22 with Society/Agency involvement = 117).

Chart 6: Child and Youth Deaths Investigated by the OCC with Society/Agency Involvement, 2019-2021

Year	Ontario deaths (age: 0-19 years)	OCC investigated (age: 0-19 years)	CYDRA – Society/Agency Involved		
			Age: 0-19 years	Age: 20-22 years	Total (age: 0-22 years)
2019	1,132	491	104	5	109
2020	1,029	436	80	2	82
2021	1,062	456	101	16	117

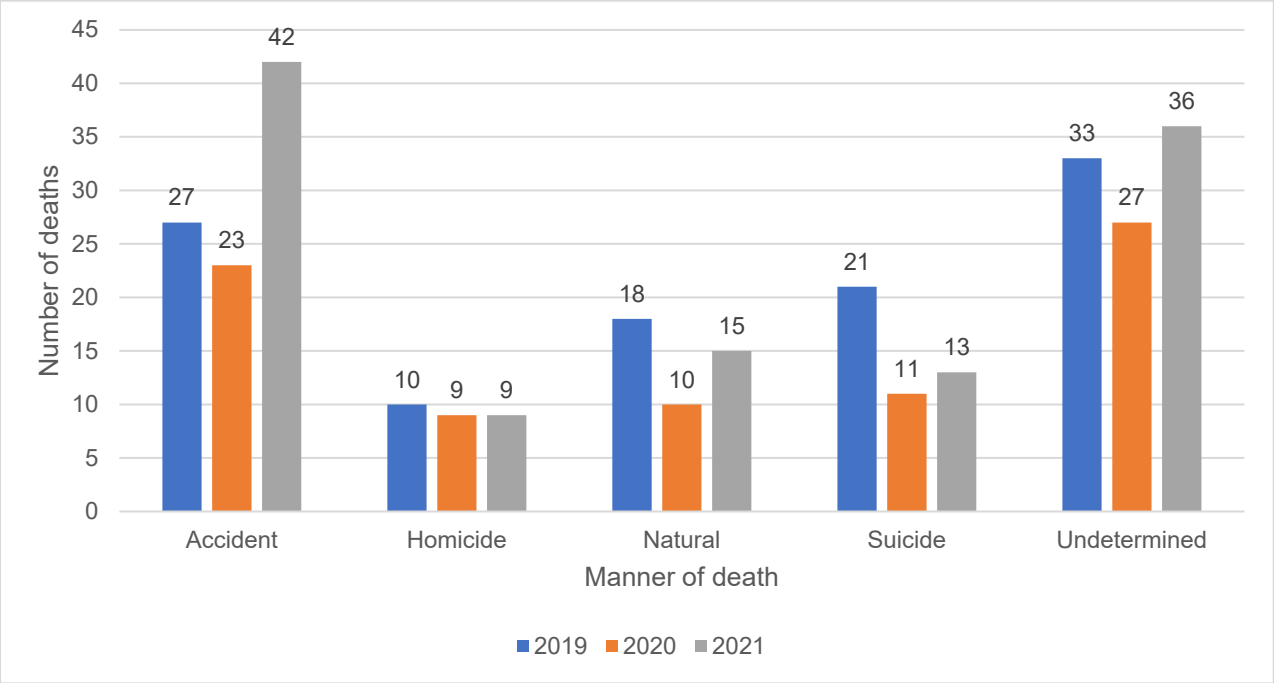
Chart 6 provides the number of child and youth deaths in Ontario, investigated by the OCC, and with Society/Agency Involvement as reported to CYDRA from 2019 to 2021. Between 2019 and 2021, approximately 22% of all deaths investigated by the OCC had a Society/Agency involvement.

Chart 7: Number of deaths of children and youth by age group with Society/Agency Involvement, 2019-2021



Between 2019 to 2021, the highest number of deaths with Society/Agency involvement were among infants and toddlers between the age 0 to 4 years, followed by youth between 15 and 19 years. There was an increase in the number of deaths among the age group 20+ years, increasing from two deaths in 2020 to 16 deaths in 2021.

Chart 7.1: Number of Deaths of Children and Youth by Manner of Death with Society/Agency Involvement, 2019-2021*



*Please note that two deaths from 2020 and two deaths from 2021 were not included in Chart 7.1. No manner of death had been determined as they were not investigated by the OCC.

Accidental deaths

Similar to the findings of accidental deaths among all children and youth investigated by the OCC, the most common death factor among those with Society/Agency involvement was acute drug toxicity, which accounted for 47% of all accidental deaths.

Deaths With Society/Agency Involvement – In Care

Children and youth were counted as being 'in care' when they were identified by the Society/Agency as being in extended Society/Agency care, interim Society/Agency care, were the subject of a temporary care agreement, or were in 'kinship care'. Individuals who are legally 'in care' may be in various living arrangements, including foster care, residential care or may be temporarily staying with family at the time of death.

A child or youth in 'Customary Care' is a First Nations, Inuit, or Métis young person, legally in the care of a person who is not the child's parent, according to the custom of the child's band, First Nation, Inuit or Métis community.

Deaths With Society/Agency Involvement –VYSA Or CCSY

Voluntary Youth Services Agreement (VYSA) is an agreement under Section 77(1) of the Child, Youth and Family Services Act (CYFSA) between a society and a youth who is 16 or 17, for services and supports to be provided for the youth where,

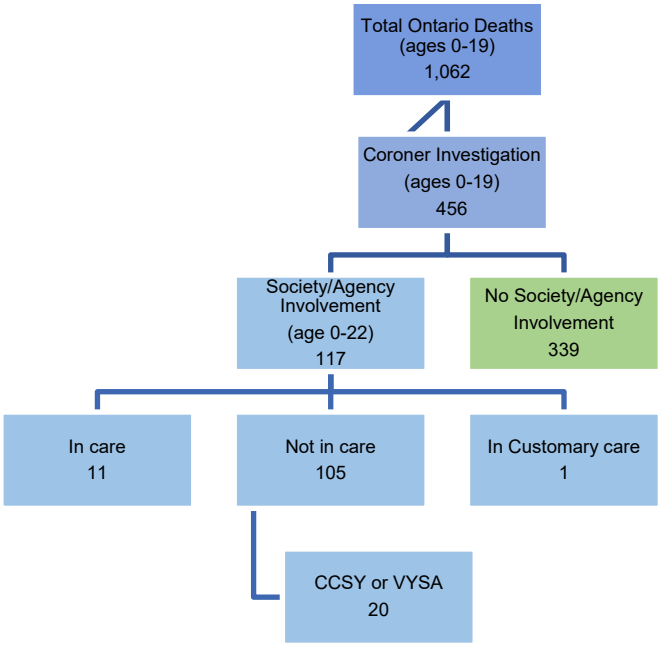
(a) the society has jurisdiction where the youth resides;
(b) the society has determined that the youth is or may be in need of protection;
(c) the society is satisfied that no course of action less disruptive to the youth, such as care in the youth's own home or with a relative, neighbour or other member of the youth's community or extended family, is able to adequately protect the youth; and
(d) the youth wants to enter into the agreement.

Continued Care and Supports for Youth (CCSY) is for eligible youth aged 18 extending to their 21st birthday. CCSY provides youth with financial (minimum of $850/month) as well as non-financial supports, to help youth meet their goals during their transition into adulthood. CCSY is voluntary for the youth, but societies are required to provide these supports to eligible youth. All youth receiving supports through CCSY (financial or non-financial) must have a CCSY agreement. Agreements are renewed yearly until the youth's 21st birthday and are up to 12 months in duration.

Deaths With Society/Agency Involvement – Customary Care

Children and youth were counted as being in "Customary care" when they were the subject of a customary care agreement.

Chart 8: Children and Youth Deaths with and without Society/Agency Involvement In 2021



In 2021, there were 117 deaths of children and youth with Society/Agency involvement. At the time of their death, one child was in customary care and 11 children were in care. Of those not in care, 20 youth were receiving supports through the CCSY or VYSA program.

Children And Youth in Care – 2019 to 2021

Between 2019 and 2021 there were 28 deaths of children and youth in care of the Society/Agency, with 12 deaths in 2019, a decrease to 5 deaths in 2020, and then an increase to 11 deaths in 2021. Over the three years, the highest number of deaths for children in care were within the age group of 0 to 4 years. The most common manner of death was undetermined, followed by accident for all three years.

Children and Youth on VYSA or CCSY Agreement – 2019-2021

From 2019 to 2021, there has been an increase in the total number of reported/investigated deaths of youth with VYSA or CCSY agreements to receive financial or non-financial support. In 2019 there were five youth that were under these agreements at the time of their death, and this increased to 10 youth in 2020, and 20 youth in 2021.

Accident was the most common manner of death among the youth on VYSA or CCSY for all three years. In 2021, 75% of the accidental deaths among these youth were attributed to acute drug toxicity.

Deaths of Indigenous Children and Youth with Society/Agency Involvement Investigated by the Office of the Chief Coroner

The ability to undertake meaningful analysis of the deaths of Indigenous children and youth served by societies/agencies is affected by limited data available to the OCC. Coroners may not identify children and youth as Indigenous as they rely on the information available during their investigation (information sources include but are not limited to family members, community service providers and police). This affects the determination of the true number of Indigenous children and youth deaths that were investigated by the OCC. For the purposes of this analysis, children and youth are identified as Indigenous if they were involved with one of the 13 Indigenous Child and Well-being Agencies in Ontario. In addition, children were identified to be Indigenous if any non-Indigenous children's aid society made note of their identity in any documents reported to CYDRA.

Summary statistics using available data have been provided; however, given the noted limitations, meaningful inferences cannot be made. The OCC and CYDRA anticipate that with the future changes to the child and youth death review model, the quality and availability of data relating to Indigenous children and youth will be enhanced to support analyses that may inform prevention strategies targeted to Indigenous children and youth.

Analysis – Indigenous Children and Youth

In 2019, the deaths of 37 children and youth between the ages of 0 and 22 were identified as Indigenous with Society/Agency involvement. There was a slight decrease in the following years, with 25 deaths in 2020 and 31 deaths in 2021.

Chart 9: Number of Deaths of Indigenous Children And Youth with Society/Agency Involvement by Age Group, 2019-2021

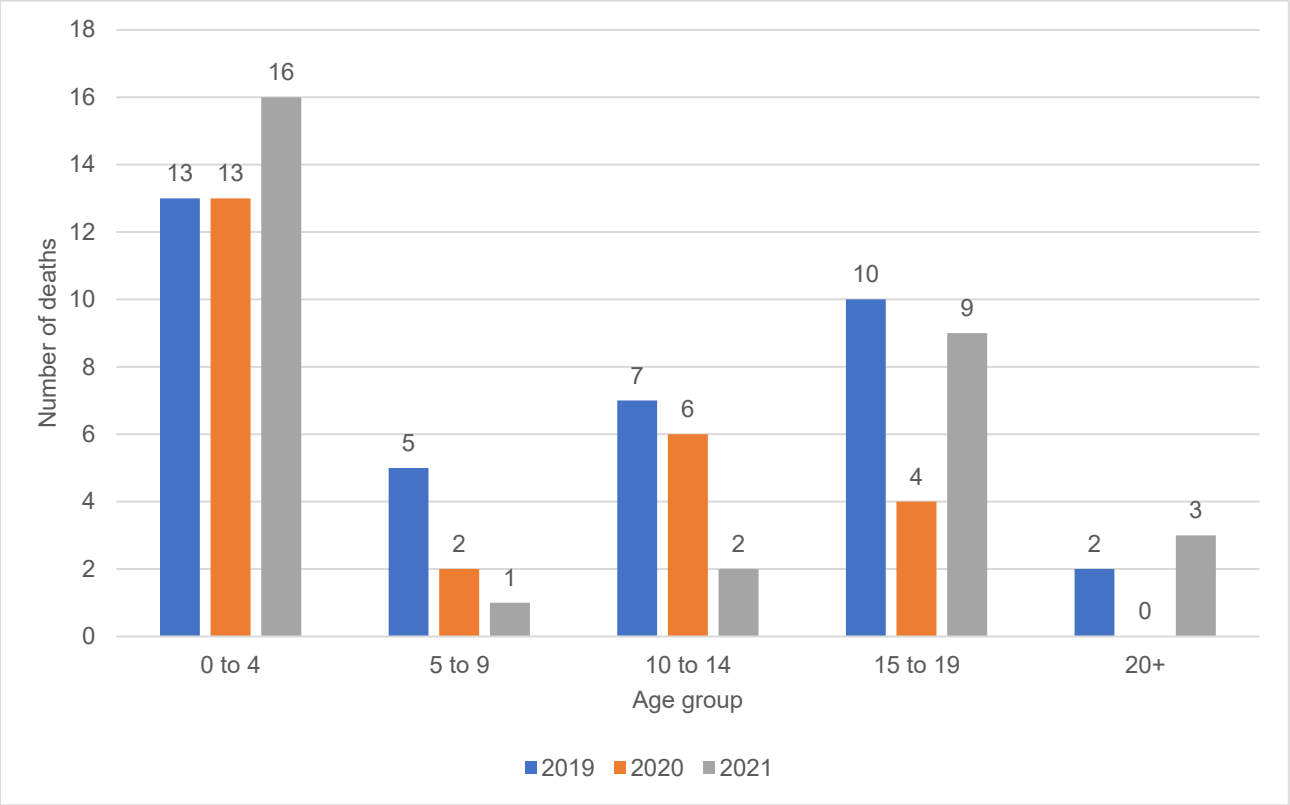
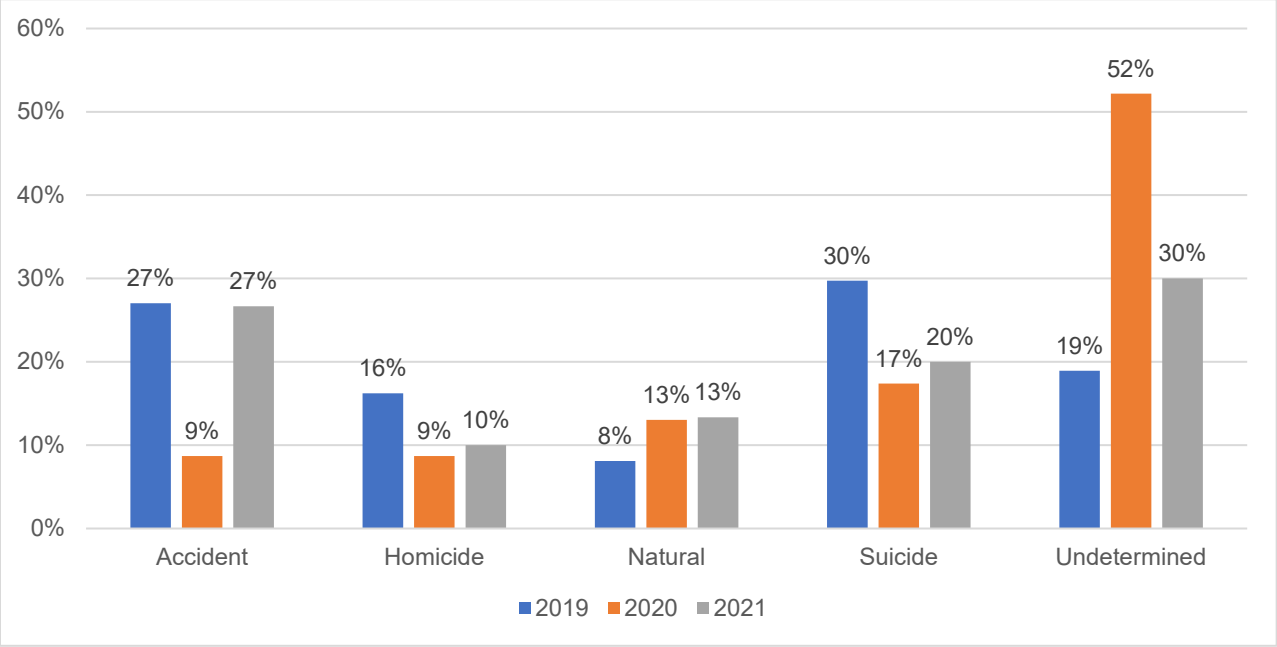


Chart 9 displays the number of deaths of Indigenous children and youth with Society/Agency involvement between 2019-2021 by age groups. The highest number of deaths were among children between 0 and 4 years over each of the years, with a slight increase in 2021. Between the age groups 5-9 years to 15-19 years, there is a slight decrease in number of deaths in 2021, but an increase in 2021 for the 20+ age group. The overall age distribution of deaths among Indigenous children and youth is similar to the distribution for all deaths with Society/Agency involvement regardless of Indigenous identity (chart 7).

Chart 9.1: Deaths of Indigenous Children and Youth with Society/Agency Involvement by Manner of Death, 2019-2021*



* Please note two deaths from 2020 and one death from 2021 were not included in Chart 9.1. No manner of death had been determined as they were not investigated by the OCC.

In 2019, the most common manner of death was suicide, this accounted for 27% of the deaths among Indigenous children and youth with Society/Agency involvement. Percentage of deaths by suicide among this population decreased over the following two years. In 2020 and 2021 the most common manner of death was undetermined, followed by suicide in 2020, and accident in 2021.

Indigenous Children and Youth In-Care, Customary Care, CCSY Or VYSA

In 2019 and 2020, 20% of all children in care were Indigenous at the time of their death. There were no children in customary care in 2019, but there was 1 child in customary care in 2020. In 2019, 20% of all youth receiving supports from CCSY were Indigenous, which decreased to 10% in 2020.

In 2021, 36% of all children in care were Indigenous and there was one child in customary care at the time of their death. Of all the youth receiving supports from CCSY, 20% were Indigenous.

Analysis of Factors Identified through Case Reviews

Through case reviews, CYDRA accesses information that, when tracked over time, may identify emerging trends. This knowledge can help contribute to understanding how services may be enhanced to improve the safety of children who are involved with the child welfare system. *(Definitions which describe the criteria for these factors can be found in Appendix B)*.

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

Recommendations

CYDRA offers recommendations to Societies, Agencies and others arising from review of the investigation materials and the different death review processes. The recommendations are aimed at the prevention of further deaths including suggestions for enhancement or change in practice and/or procedures that may inform improvement in service delivery and potentially impact child and youth safety and well-being. These recommendations are sent out with a request for response from the receiving organization, and responses are tracked by the CYDRA unit.

The following table lists the categories and themes:

Category	Theme
Service Level Community Collaboration	Case Conference
	Service Coordination and Community Intervention/Development
	Community Collaterals
Education/Training	Education/Training - Client Engagement
	Education/Training - Family Violence
	Education/Training - Human Trafficking
	Education/Training - LGBTQS2+
	Education/Training - Mental Health
	Education/Training - Other
	Education/Training - Safe Sleeping
	Education/Training - Substance Use
	Education/Training - Supervisor Training
	Education/Training - Trauma Informed
Organizational-Focused	Practice
	Protocols
	Staff Supervision
	Guidelines/Standards
	Service Delivery
	Monitoring and Evaluation
	Review Existing Reports
	Placements for Children and Youth

Category	Theme
System Level Change	Inter-ministerial Collaboration
	Legislation
	Policy
	Funding
Assessment	Investigations
	Risk Assessment
	Screening/Diagnosis
	Signs of Safety
Family Support	Family Support - Disability
	Family Support - Family Access
	Family Support - General
	Family Support - Medical
	Family Support - Mental Health Services
Youth Support	Support to Youth
Systemic	Cultural Safety
	Anti-Racism
	Anti-Oppressive

Recipient Organizations

The reviews conducted by CYDRA have resulted in several recommendations on service level, systemic, and structural levels. The recipient organizations include, but are not limited to, the following:

- Children's Aid Societies / Indigenous Child and Family Well-being Agencies
- Ministries (Education, Health, Solicitor General, and Children, Community and Social Services)
- Federal Government
- School Boards
- Hospitals

The following are examples of recommendations provided to outside organizations.

1. Education/Training with regards to Human Trafficking.

The Ontario Association of Children's Aid Societies (OACAS) to conduct a review of children's aid societies to determine whether:

(a) They have received training regarding the risks related to human trafficking for youth in residential placements and that the training is trauma-informed.

(b) They have included language regarding human trafficking in their protocols with police services.

2. An LDRT policy recommendation was made to affirm anti-racism and anti-oppressive practice within the education system:

All school boards to adopt a relational policy framework as a companion to 'Promoting a Positive School Climate'. Several resources should be developed as a part of this work: A review of job descriptions for school administration and staff to include relational aspects as a core competency. As a result, job descriptions, starting with principal and vice-principal, should be examined and revised to explicitly detail a primary requirement for these professionals to build and foster relationships with and amongst students, above any other authoritarian or administrative requirement of the role. The relational framework should be accompanied by a practical resource that can be applied to the entire school, the classroom and/or to students, and that this be developed using an anti-oppression and anti-racism lens.

Conclusion

The OCC, PDRC-Medical and CYDRA believe that the clear understanding and accompanying data are valuable to provide a better understanding of paediatric deaths with and without child welfare Society/Agency involvement in Ontario. The OCC continues to receive feedback from many parties about the value of the approach and the utility of the information.

The OCC looks forward to the continued work with many, at the individual and organizational levels toward the shared goal of improving the health, safety and well-being of Ontario's children and youth.

Appendices

A. Death Review Processes for Children and Youth

B. 2006 Joint Directive on Child Death Reporting and Review

C. Data Sources and Data notes

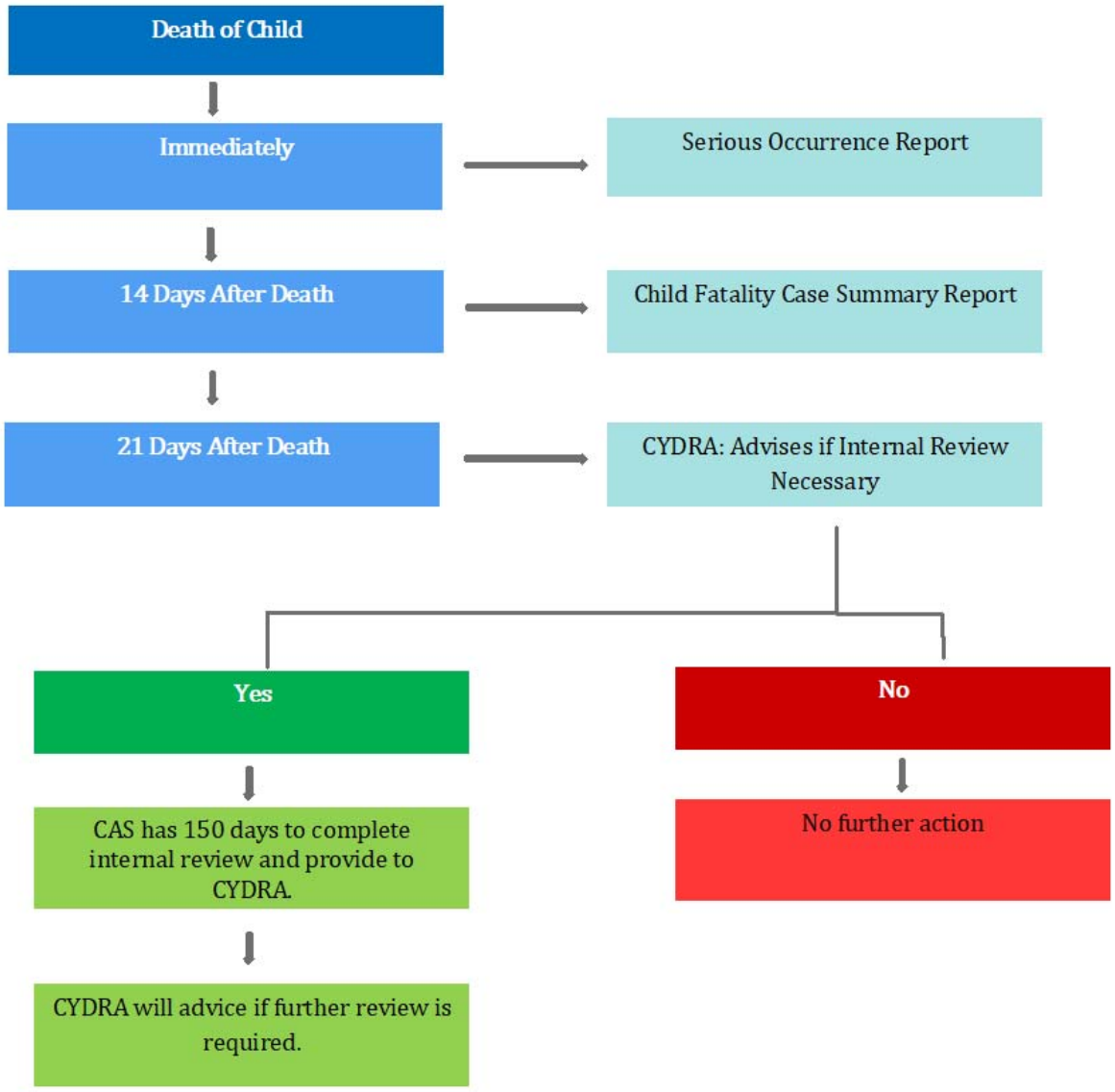
Appendix A: Child and Youth Death Review Processes

Death review process	Description
Interim Paediatric Death Review Committee-Children and Youth for Indigenous children and youth	This interim process provides an Indigenous-specific approach, broadens the review beyond child welfare to include education, children's mental health, and youth justice, and supports the incorporation of systemic and structural realities into the analysis and final recommendations. This review committee includes Elders and knowledge keepers, individuals from the Association of Native Child and Family Services Agencies of Ontario, members from Ontario Indigenous child and family well-being agencies, the Indigenous Justice Division, and the Office of the Children's Lawyer.
Interim Paediatric Death Review Committee-Children and Youth	The Interim PDRC-CY review process broadens the review beyond child welfare and includes a core team of individuals from the Ontario Association of Children's Aid Societies, MCCSS regional representation, child welfare, youth justice, education, Office of the Children's Lawyer and the Ministry of Health. In addition, individuals who hold specialized knowledge specifically relevant to the death are also invited. The process strives to be trauma-informed, intersectional, and anti-oppressive.
Local Reviews co-developed through First Nation led Protocols	When requested, CYDRA is actively engaging with the First Nations to develop local protocols for death review processes ensuring that the death reviews for First Nation children and youth respect the inherent rights and jurisdiction of First Nations. Local death review protocols are centered upon recognizing the sacredness of the death review work, honoring the lives of children and youth and learning what their lives continue to teach us while incorporating anti-racism and anti-colonial processes into death review.
Local Death Reviews	An intersectoral approach in which individuals who worked directly with the child/youth are brought together in addition to individuals with specialized knowledge specifically relevant to the death to review the journey of the deceased child or youth. The family perspective is presented in the table as an integral part of the review process.
Expert Reviews	In cases where specific sectors are intricately involved and/or there are complex technical aspects, CYDRA may engage a subject matter expert who can review and provide analysis of specific records, information and provide analysis that speaks to the issues that impacted the life of the child or the young person (e.g., medication reviews, psychiatrist records, various types of educational and mental health assessments).
Other Death Review Processes	To learn more about the deaths of children or youth and inform system changes, other processes may be considered including aggregate reviews relating to a systemic issue, requests for internal reviews, review of policy, case conferences with the agency staff and others.

Appendix B: 2006 Joint Directive on Child Death Reporting and Review

This chart outlines the process and timelines arising from the 2006 Joint Directive between the OCC and MCCSS for Child Death Reporting and Review.

Joint Directive Flow Chart – Office of the Chief Coroner and Ministry of Children, Community and Social Services (formerly, Ministry of Children and Youth Services), pertaining to Ontario Children's Aid Societies



The timelines as outlined have not been updated since the revision to the Joint Directive in 2006. While the OCC and CYDRA strive to meet the timelines for review decisions as outlined, there are a number of circumstances that impact and often delay this ability. For example, ongoing coroner's investigations, police investigations, criminal proceedings. Most often, a decision cannot be made and a death cannot be moved forward for a child and youth death review process until these investigations and proceedings have concluded.

Society Internal Child Death Reviews

When is a Society Internal Child Death Review requested for a child or youth?
CYDRA reviews the Society/Agency Child Fatality Case Summary Report and the Coroner's Investigation Statement (CIS) and considers the following criteria when deciding if the Society/Agency will be requested to conduct and forward an Internal Review to CYDRA:

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

Why is a Society Internal Child Death Review requested?
An internal child death review is requested by CYDRA for the purposes of conducting an analysis of the context within which the death occurred. Internal child death reviews provide an opportunity for individual Societies/Agencies, and the child welfare sector as a whole, to learn from child/youth deaths with a view to identifying areas of potential improvement to Society/Agency policies, practices and procedures.

Who completes the Society Internal Child Death Review?

When CYDRA requests that a Society/Agency undertake an internal child death review, the Society/Agency is required to establish a review team which must include an independent external reviewer with appropriate clinical expertise.

Appendix C: Data sources and Data notes

Data Sources

- Coroner's death investigation case management systems, Ontario Office of the Chief Coroner. Extracted August 10, 2023.
- Statistics Canada. Table 13-10-0709-01, Deaths, by age group and sex, last accessed August 28, 2023
- Historical Population Estimates, Analysis for 2022, Ministry of Finance. Extracted January 2023

Exclusion criteria

This section outlines the exclusion criteria to create the cohort for the analysis of this report. Any deaths that met any of the follow criteria were excluded from the cohort.

- Missing age
- Date of birth or death was missing.
- Where death factor was listed as skeletal remains, stillbirth or pre-term pregnancy loss.
- Natural hospital deaths

Any person seeking to reproduce data or information from this report is asked to contact the Office of the Chief Coroner to ensure accuracy.

Contacts:

Child and Youth Death Review and Analysis Unit
Dayle Espiritu – Senior Program and Policy Lead/Specialist
Phone: 437-999-6128
Tanrima Moumita - Senior Research and Statistics Advisor
Phone: 437-246-4347

Dr. Joel Kirsh, BASc, MSc, MD, MHCM, FRCP(C)
Chair, Paediatric Death Review Committee - Medical
Regional Supervising Coroner, Central East Region
Phone: 416-314-4000