June 2004

First Report of the Paediatric Death Review Committee

Office of the Chief Coroner
Province of Ontario

Special points of interest:

- PDRC Case Reviews for 2002/03
- Cases with CAS Involvement
- Deaths Under Two Years of Age
- SIDS, SUD and Co-sleeping
- Themes
- Future Directions

Inside this Report:

Message from the Chair, Paediatric Death Review Committee

I have chaired the Paediatric Death Review Committee (PDRC) since its formation in 1991. Initially it was formed to assist Coroners with complex medical cases. All the members of the Committee were experts in different fields of Paediatrics. Within a few years, the Committee started to become extremely interested in children who died under age two and produced a detailed protocol for the investigation of these deaths.

Once this protocol was in active use (1995), certain death patterns started to appear and by 1996, issues were arising regarding the deaths of children who were being monitored by Children's Aid Societies (CAS). This resulted in a number of inquests and a report by the Joint Mortality Task Force.

In 1997 a decision was made that all deaths of children who died with an open CAS file would be reviewed by the Paediatric Death Review Committee. To do this successfully, it was necessary to enlarge the Committee to include experts in child welfare, the police and the Crown Attorney's office. This has enabled the Committee to become truly a multi-disciplinary Committee and I feel it has greatly enhanced the ability to look at all aspects of children's death.

As the Committee has matured, new initiatives have been undertaken and a new sub-committee has been formed that reviews all deaths under the age of two as a means of quality control. This has resulted in a decision to only have the autopsies of children under two done at four centres in the Province of Ontario: (1) Ottawa; (2) Toronto; (3) Hamilton; and, (4) London.

It is important to note that although the Committee has been in existence since 1991, this is the first time we have been able to actually present a written report. This has been mainly due to the fact that the case load had increased and all the Committee's time was taken up with the actual reviews themselves. With additional support staff, it is our hope that we will be able to present a report from the Paediatric Death Review Committee on an annual basis from now on.

In closing, I would like to sincerely thank my Executive Officer, Dorothy Zwolakowski for all the hard work she has done for the Committee and for having done the lion's share of the work in preparing this report.

This report is dedicated to all the children who have died unnecessarily since 1991. It is our sincere hope that by analyzing these deaths, we can help prevent similar deaths in the future.

Dr. Jim Cairns, Deputy Chief Coroner for Ontario
Chair, Paediatric Death Review Committee

Terms of Reference: Paediatric Death Review Committee

"To determine the cause and manner of death"

1. To determine the cause and manner of death
2. To determine in medical cases, that the appropriate diagnosis was rendered
3. To provide expert evidence at Inquests
4. To do, or promote research where appropriate
5. When directed, to undertake random reviews, or directed reviews
6. To provide advice to police and crown attorneys where criminal charges result from a child's death; may also provide expert evidence in criminal cases
7. To provide or stimulate educational activities through identification of problem issues and/or:
   - referral to agencies for action
   - development of protocols
   - disseminate educational information to parents, hospitals/ professionals, child welfare agencies, government ministries and others

Manners of Death

Death classification falls into one of five categories

In the Province of Ontario, deaths are classified into five categories:

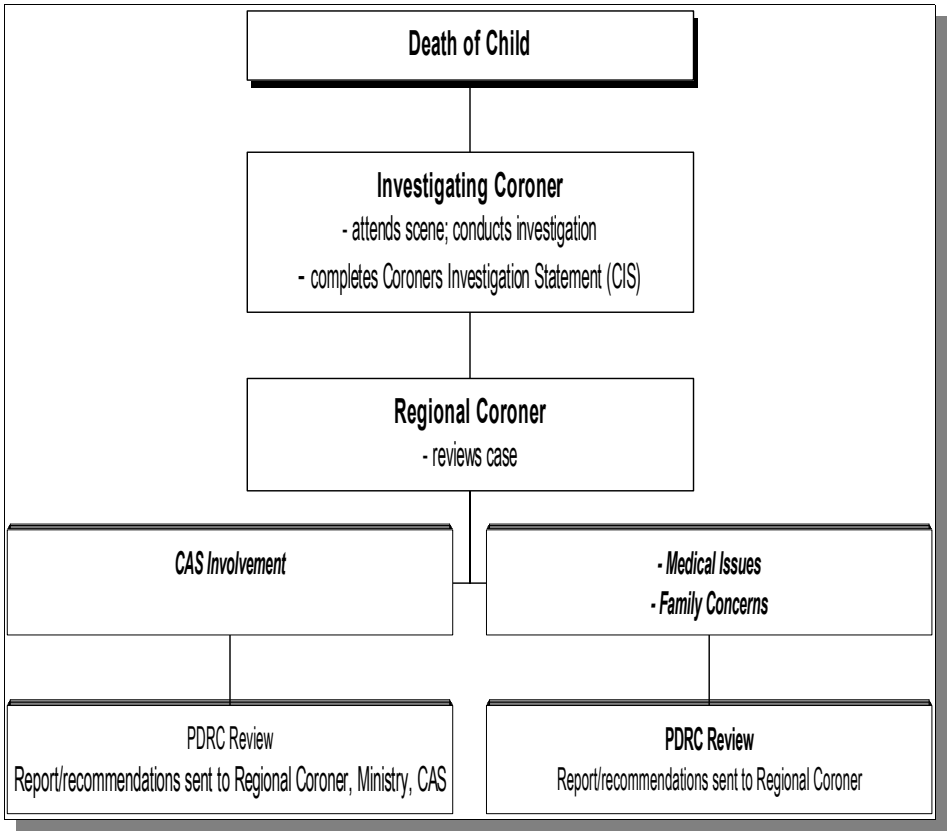
1. **Natural:**
   Death that is due to a natural disease, or a complication of a disease, or its treatment.
2. **Accidental:**
   Death that is due to an occurrence, incident or event that happens without foresight or expectation.
3. **Homicide:**
   Death that is due to the action of one human being killing another human being.
4. **Suicide:**
   Death that is due to an intentional act of a person knowing the probable consequence of what he/she is about to do.
5. **Undetermined:**
   Inadequate evidence for classification; equal evidence, or a significant contest for two or more classifications; suicide which does not meet higher standard of proof.

Child Death Review Process in the Province of Ontario

The Province of Ontario currently has over 300 coroners who conduct investigations across the province. The province is divided into nine regions with a *Regional Supervising Coroner* overseeing the investigations in each region.

All cases where the deceased child had an open file with a Children's Aid Society (CAS) at the time of death are reviewed. The Committee reviews medically complex deaths where the cause and/or manner of death may be in question, or where the standard of medical care is in question. The Committee also reviews cases where concerns are raised by family members or caregivers.

The Regional Supervising Coroner, having decided that the case requires a review, will forward the entire file, including the Coroners Investigation Statement, autopsy report, toxicology report, x-ray report, police report and in cases where the CAS is involved, the entire CAS file to the PDRC for review.



The contents of the file are distributed to the various experts on the Committee and a report is generated by a Committee member who is designated as the primary reviewer. At the monthly meeting, the entire Committee discusses the report and a consensus report, including recommendations, is confirmed by all members. The report is then forwarded to the Regional Coroner, the Investigating Coroner and in cases where the CAS is involved, the supervising agency and the Ministry of Community and Social Services (MCSS)/Ministry of Children and Youth Services (MCYS). The Regional Supervising Coroner may decide to send the recommendations to other agencies depending on the case.

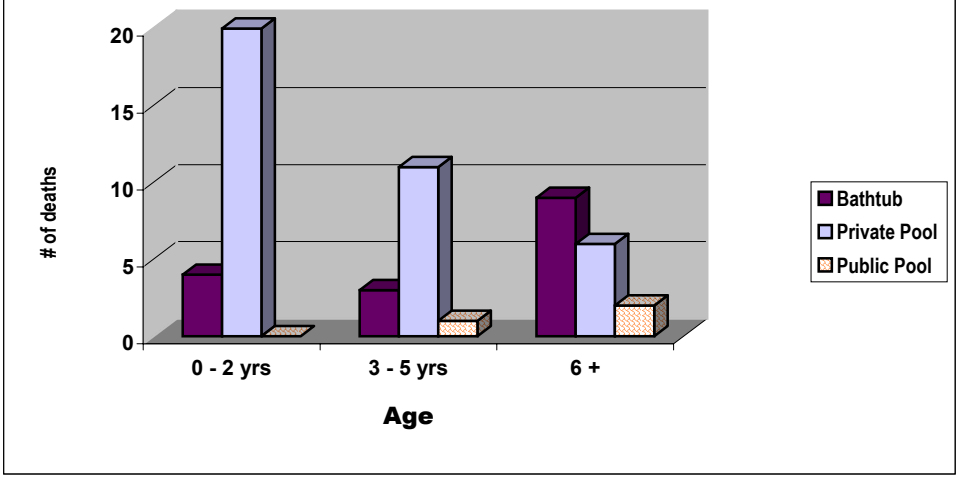
Accidental Deaths

Accidental deaths are the second highest percentage of children's deaths investigated by the Office of the Chief Coroner.

Drownings:
This graph depicts data collected on bathtub, private and public swimming pool drownings.

Over the five year period, 1998 to 2002, there were 56 accidental drownings involving children up to age 18. The majority of deaths occurred in the 0 to 2 year age group in private pools.

Drownings: 1998—2002



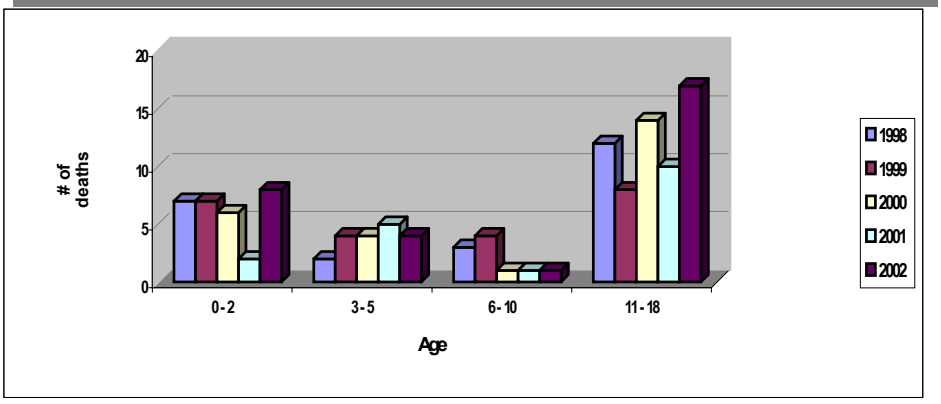
Homicides

Homicide is defined as "death that is due to the action of one human being killing another human being".

This graph shows the total homicides broken down by age groups over the period 1998 to 2002.

This once again demonstrates the importance of a thorough investigation for the deaths of children under the age of two.

Homicides: 1998 to 2002



Children's Deaths in Ontario (0 to 18 years of age): 1995 to 2000

The following table summarizes the children's deaths investigated by the Office of the Chief Coroner on an annual basis. The statistics for 2001 and 2002 remain preliminary at the time of printing and are therefore not included. The deaths reviewed by the PDRC represent a fraction of the total number of children who died in Ontario. Those will be discussed in further detail later in the report.

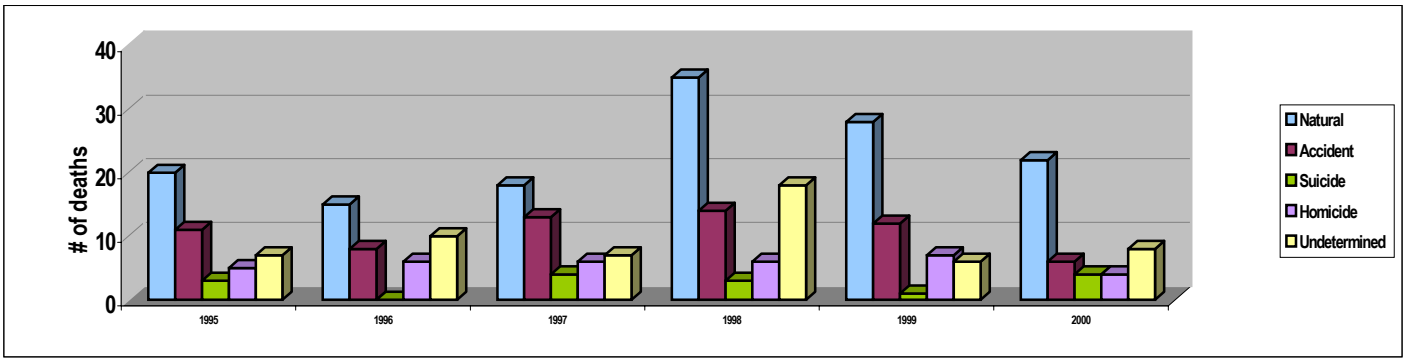
The following percentages represent the total deaths by manner over this six-year period. Clearly, the largest numbers fall into the *natural* and *accidental* categories.

Natural:	**44%**
Accidental:	**36%**
Suicide:	**8%**
Homicide:	**4%**
Undetermined:	**7%**

MANNER	1995	1996	1997	1998	1999	2000
Natural	320	283	268	283	236	240
Accident	256	223	258	226	223	214
Suicide	62	40	57	51	56	59
Homicide	28	34	32	24	23	25
Undetermined	53	46	40	47	40	42
Total Deaths:	**719**	**626**	**655**	**631**	**578**	**580**

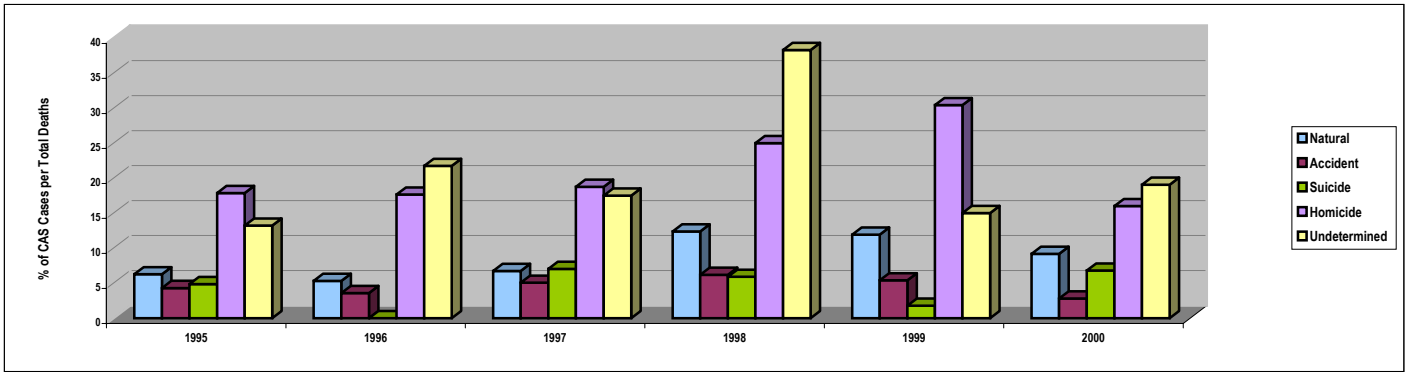
Coroners Cases with Children's Aid Involvement: 1995 to 2000 (By Manner of Death)

This graph illustrates the total number of children who died while having an open case with CAS at the time of death, or in the 12 months preceding their death. Data is captured by manner of death and by year.



Percentage of Cases Involving Children's Aid per Total Number of Children's Deaths in Ontario: 1995 to 2000

The graph below shows the percentage of cases investigated by the Coroners Office where a Children's Aid Society had involvement with a child prior to death. The percentage is derived by comparing the total number of CAS cases to the total number of children's deaths in the Province of Ontario over the period 1995 to 2000. The data is also illustrated by manner of death.



Child Death Reviews in 2002 and 2003: By Manner of Death

The total number of cases reviewed by both the Paediatric Death Review Committee and the Deaths Under Two Committee are quite high. The intake, preparation and review are time and resource consuming, and therefore, our resources are consumed primarily by ensuring a detailed review is conducted.

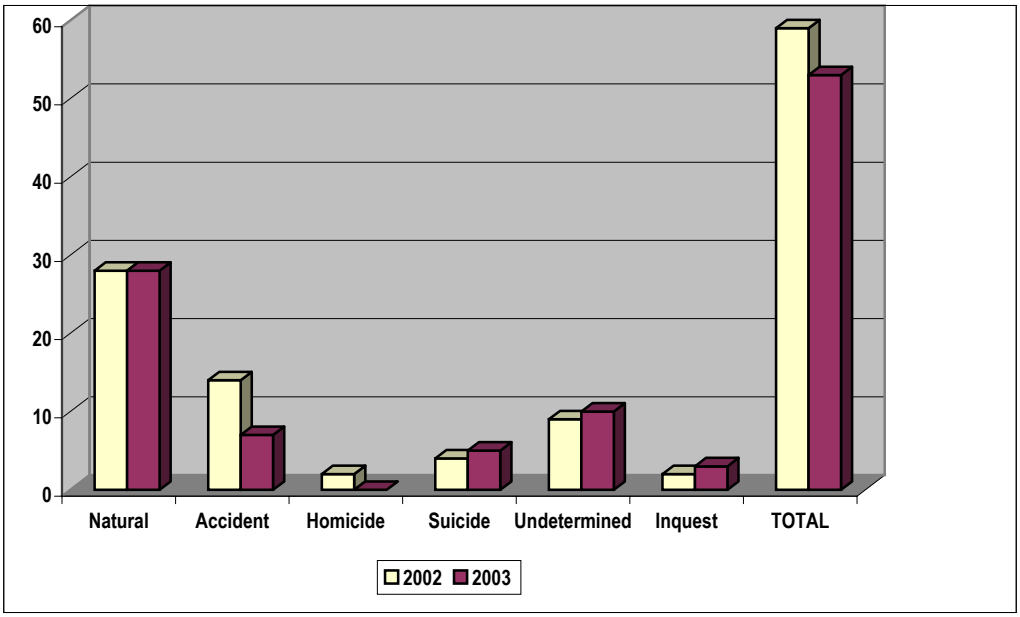
In 2002, 59 cases were reviewed by the Paediatric Death Review Committee, and of those, 32 cases had Children's Aid Society involvement with the child prior to their death. Of the 32 cases, 1 went to inquest.

2002

In 2003, the PDRC reviewed a total of 53 cases. 28 of those cases had Children's Aid Society involvement with the child prior to their death. The 3 cases recommended for inquest were of a medical nature and had no Children's Aid Society involvement.

2003

Manner of Death	2002 Reviews	Cases with CAS Involvement	2003 Reviews	Cases with CAS Involvement
Natural	28	9	28	10
Accident	14	10	7	6
Homicide	2	2	0	0
Suicide	4	4	5	5
Undetermined	9	7	10	7
Went/Going to Inquest	*2*	*1*	*3*	*0*
Total Case Reviews:	**59**	**32**	**53**	**28**



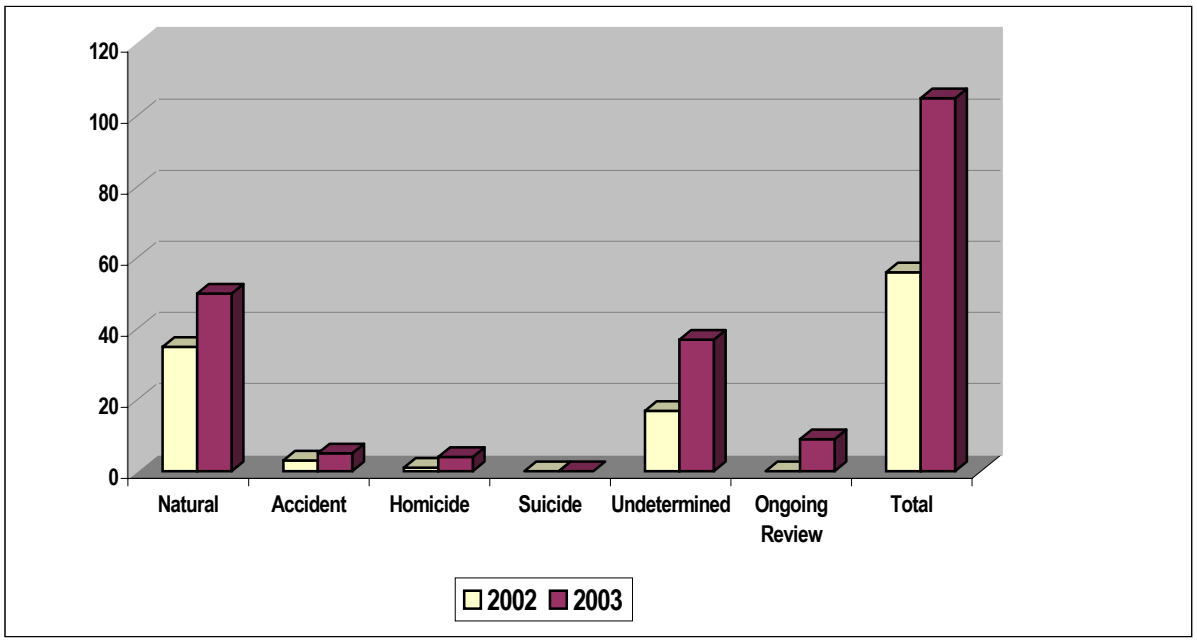
Deaths Under Two Years of Age: Case Reviews for 2002 and 2003

The complexities of paediatric forensic pathology have become increasingly apparent across the province over the years. This has been recognized by the Office of the Chief Coroner and resulted in the implementation of an Investigation Protocol for Deaths Under Two Years of Age (1995) and then a revised Investigation Questionnaire for the Sudden and Unexpected Deaths of Children Under Two Years of Age (2001). Recognizing that paediatric death investigation is unique in itself, a protocol was developed in March 2002, directing that all medicolegal autopsies of children under the age of two years be conducted in one of four regional paediatric centres, those being London, Hamilton, Toronto and Ottawa. It was determined that these four centres provide a full spectrum of paediatric subspecialty services such as: pathology, radiology, ophthalmology, surgery, child abuse and neglect, and general paediatric medicine; and that this protocol would ensure the best use of provincial paediatric resources and expertise in the course of paediatric death investigation.

To that end, a special sub-committee was formed under the auspices of the PDRC to review all deaths under two years of age to ensure a complete investigation has transpired. The Committee membership includes pathologists, coroners and police. They meet monthly and the following summarizes the cases reviewed of children under two years of age who died in the Province of Ontario. In some instances, cases may be referred to the PDRC for further review (e.g. medically complex cases, cases with CAS involvement).

Manner of Death	2002* Case Reviews	2003 Case Reviews
Natural	35	50
Accident	3	5
Homicide	1	4
Suicide	0	0
Undetermined	17	37
Ongoing Review	*0*	*9*
Total	**56**	**105**

** The sub-committee's first formal year of reviews*

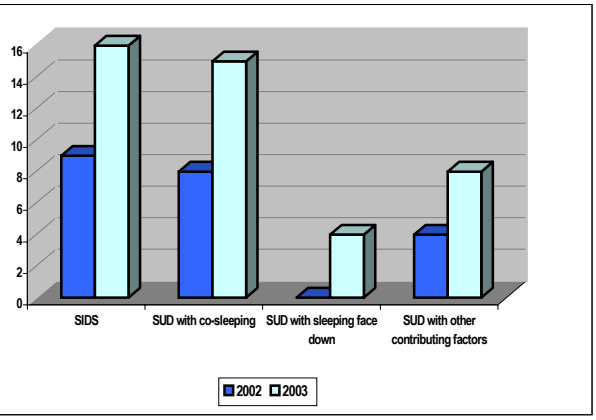


SIDS: Sudden Infant Death Syndrome

SIDS is a <u>diagnosis of exclusion</u>, providing all other aspects of the death investigation are negative.

Sudden infant death syndrome is defined as the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, which must include a complete autopsy, examination of the death scene, a police investigation and a review of the clinical history.

It is clear from this definition that the diagnosis of SIDS can only be considered when all the components of the investigation have been completed and nothing abnormal or suspicious has been discovered. *SIDS is really a diagnosis of exclusion.*



SUD: Sudden Unexpected Death in Infancy

Contributing Factors Include:

- Co-sleeping
- Sleeping face down
- Unconventional sleeping surface

If <u>any</u> part of the death investigation in a child under one year of age is positive, then the death <u>should not</u> be classified as a SIDS. The following are some examples where this would apply:

A) Negative autopsy but evidence of an old healed fracture which has not been adequately explained by the investigation
B) Negative autopsy but a previous history of child abuse
C) Negative autopsy but some positive toxicology which although not considered to be a cause of death cannot be explained.

The following chart summarizes the cases reviewed by the Committee of children under two years of age who died as a result of Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death (SUD) in infancy. It was found that some infants who died of SUD had other factors that may have contributed to their death such as co-sleeping with an adult, or sleeping on their stomach face down. The manner of death in SIDS is classified as natural, while SUD cases are classified as undetermined.

In 2003, of the 105 death reviews of children under two years of age, the cause of death in 16 of those cases was SIDS. Of the total reviewed, 19 cases were classified as SUD with co-sleeping or sleeping face down as contributing factors. An additional 8 cases were classified as SUD with other contributing factors (i.e. environmental hyperthermia, unsuitable sleeping surface).

Cause of Death	2002	2003
SIDS	9	16
SUD *with co-sleeping*	8	15
SUD *with sleeping face down*	0	4
SUD *with other contributing factors*	4	8
TOTAL SIDS/SUD	**21***	**43**

* Sub-committee's first year of reviews

Retrospective Review of SIDS/SUD: 1995 to 1999

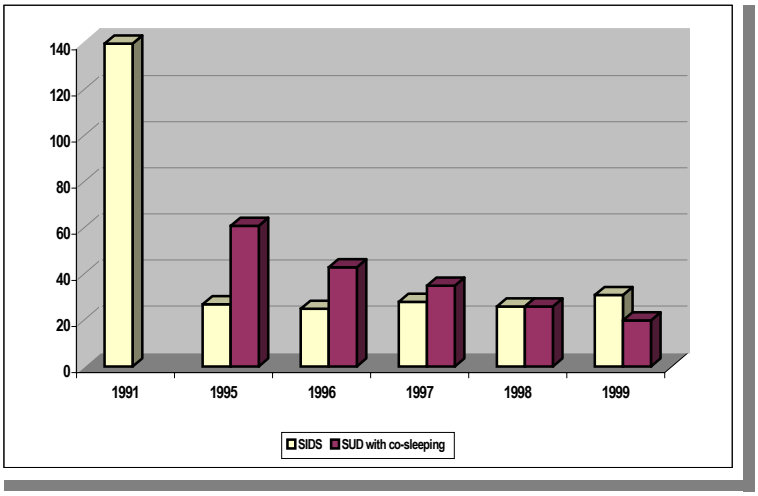
A retrospective file review was conducted for the years 1995 to 1999 to determine the prevalence of SIDS and SUD with co-sleeping. It is evident from the file review that the number of SIDS deaths have remained fairly consistent over this five year period, whereas the SUD deaths with a co-sleeping involvement were nearly double that of the SIDS cases in 1995 and the Committee has seen a decrease over the years. It is noted that there are nearly an equal number of SUD cases with co-sleeping involvement as there are SIDS cases annually.

Cause of Death	1995	1996	1997	1998	1999
SIDS (in crib)	27	25	28	26	31
SUD (with co-sleeping as a factor)	61	43	35	26	20
TOTALS:	**88**	**68**	**63**	**52**	**51**

This data was collected from the review of 322 files of infants, less than 1 year of age, contained within the Coroners System in Ontario.

In 1991, there were approximately 140 SIDS deaths in the Province of Ontario. Clearly, since that time, the numbers have decreased. The reasons being:

1) **Education**: Back to Sleep Program - referring to placing a baby on their back (supine position) when putting them down to sleep.
2) **Stricter Definition of SIDS:** The Office of the Chief Coroner uses the National Association of Medical Examiners (NAME) guidelines when classifying infant deaths. This allows for consistent classification in the Coroners system.
3) **Deaths Under Two Investigation Questionnaire:** Designed by the Coroner's Office, the questionnaire assists coroners and police officers to ensure that all aspects of a comprehensive scene investigation are covered.



Overlaying deaths are those caused by persons that accidentally lay on top of, and smother, a child. Infants are at increased risk for overlaying death as they are often not strong enough to move their heads or bodies. The identification of these cases is made even more difficult by the fact that most infants who suffocate by overlay do not have clinical signs at autopsy. Thus, it becomes critical that a thorough scene investigation is conducted by both the coroner and the police.

Infants who sleep with adults are at increased risk of overlay death especially when the adults are obese and/or impaired by drugs or alcohol.

There is currently international debate regarding the pro's and con's of co-sleeping with infants. In 1997, the American Academy of Pediatrics (AAP) issued some guidelines on co-sleeping, however, they did not make any definitive recommendations. The AAP guidelines can be found at www.aap.org. The PDRC urges public health departments, maternity wards and other agencies to develop and/or continue their education efforts on unsafe sleeping environments for new families.

The PDRC also wishes to emphasize how important a thorough scene investigation, including interviews, is in these

National Association of Medical Examiners (NAME) Guidelines for Classifying Deaths

As discussed on the previous page, the Office of the Chief Coroner uses the National Association of Medical Examiners (NAME) guidelines when classifying infant deaths. This allows for consistent classification in the Coroners system.

The following NAME Guidelines have been used by the Paediatric Death Review Committee and Deaths Under Two Committee since 2002:

Definitions:
COD: Cause of Death
BWM: By What Means (Manner of Death)

Group 1	COD: A specific disease, injury, or other condition is identified as cause of death (i.e. pneumonia, CHD, overlaying, head trauma, etc) BWM: Classified as based on the circumstances
Group 2	COD: "Classic" SIDS – no cause of death identified after complete autopsy, toxicology, other lab tests, scene investigation, review of medical history. BWM: Natural
Group 3	COD: Consistent with SIDS – but evidence of a disease condition (such as focal bronchiolitis) is found but the role of the condition in causing or contributing to death is not truly known BWM: Natural
Group 4	COD: Sudden unexpected death in infancy – evidence of external condition or risk factor exists (bedsharing with adults, sleeping face down on a soft pillow or adult mattress). Again the role of the external condition/risk in causing or contributing to the death is not truly known or difficult to evaluate, prove, or disprove. BWM: Undetermined *(also list the contributing external factors)*
Group 5	COD: Unexpected and undetermined cause BWM: Undetermined

Medical Case Reviews: THEMES

Since its inception in 1991, the Paediatric Death Review Committee has compiled a number of common themes that have recurred in the review of children's deaths. Our reviews echo the findings of an increasing volume of literature on errors in medicine, which suggests that tragedies rarely result from a single fatal error or flaw and are more likely to arise from a series of imperfections in both systems and in performance. The occurrence of multiple imperfections is frequently synergistic. Imperfections, which may appear quite basic, but are seen repeatedly by the Committee are:

- Failure to ***listen*** to repeated parental concerns, particularly in the child who returns without having responded to initial management
- Failure to record or review ***vital signs***, particularly blood pressure – ***VITAL SIGNS ARE VITAL!!!!***
- Failure to make a semi-quantitative assessment of ***fluid intake and output***, particularly in the child with vomiting and diarrhea (e.g. number of loose stools, wet diapers etc)
- Failure to record ***weight*** or to use ***growth charts***
- Failure to include not only the ***date***, but the ***time*** of a chart entry
- ***Illegible*** or ***sloppy handwriting***, which is either misinterpreted by others or creates problems for a physician's defense
- Failure to record ***thought processes***, or the reasons behind certain actions – the more badly things are going, the more important charting becomes (and the less likely complete charting is to be found)
- Failure to ***follow-up on missed appointments***, especially for the "non-compliant parent and non-responsive patient"
- Failure of institution to ***meet with the parents*** after a death to discuss and review the care provided. Not infrequently, such a failure has led to a physician not only being regarded as heartless, but as having something to hide, and this may result in parents pushing for inquests where a less adversarial process may have been more helpful
- Refusal to ***accept alternative explanations*** after the event, even after review by third parties – starting with humility leads to victory, whereas starting with arrogance leads to a humbling experience

Use of Restraint

Several Coroners Inquests, Lonnee, Edgar, Jobin and Durnford, have highlighted the need for a consistent approach to training residential staff in managing difficult behaviour. The Paediatric Death Review Committee (PDRC) has also recommended the creation of a mandatory training regime for the application of physical restraint. The government has responded positively and although mandatory training is now in place, it may not address the severity of the problems identified in the inquests.

The following article was authored by the PDRC and published in the *Journal of Paediatrics and Child Health (2004 Feb: Vol 9(2); p120)* in an effort to alert and educate the medical community to the dangers of restraint in the prone (hog-tie) position.

Death Related to Restraint

This 13-year-old girl was identified at age six as having autism and mental retardation. She had difficulties with aggressive behaviour and was hospitalized in a children's psychiatric facility at age eight for assessment and management of aggressiveness and self-inflicted injuries.

After discharge to a group home setting, her behaviours were more challenging than the group home staff could manage, and the community resources to meet her complex needs were lacking.

She was again hospitalized in a children's psychiatric facility at age ten where she spent the next eight months. She had numerous trials of medications to modify her behaviour. A "bucket restraint system" was used to protect her and staff from injuries when she became aggressive. Considerable difficulty was encountered in finding an appropriate group home setting for her.

Two weeks before her death her primary case worker left the group home. Her behaviour deteriorated considerably after this. She required restraint on a daily basis up to 100 minutes per day. On the day of her death she was in restraint for two of the four and a half hours spent at school that morning. On return to the group home she was aggressive and difficult to manage. Attempts to redirect her were unsuccessful. She received 50 mg of Chlorpromazine at 1600 hours, at 1900 hours and 1930 hours (toxicology analysis later determined this medication played no role in her subsequent cardiorespiratory arrest). At 2000 hours, three staff members attempted to restrain her. She ended up on the floor in the prone position. One staff member held her legs and another placed a bean bag over her thorax, straddling her and holding her arms. Over the next twenty minutes she continued to struggle until she suddenly became motionless and stopped breathing. She was resuscitated but suffered hypoxic ischemic encephalopathy with brain death.

Sudden death related to restraint for excited delirium is well documented in the literature. [1,2,3,4,5] The Office of the Chief Coroner has issued a caution in this regard to all police departments and children and youth facilities. This case is presented to alert physicians, particularly those involved with children whose behaviour is difficult to manage, to the dangers of restraint in the prone (hog tie) position. Knowledge of inappropriate restraint procedures should be brought up immediately with the caregivers involved. A complete list of recommendations regarding this child's death can be found in the report of the Coroner's Inquest.[5,6,7] A response from the Children's Aid Society is documented in the June 2003 issue of their journal.

References

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3. Lewin, P.K. The use and abuse of restraints. CMAJ Nov 17, 1998;159(10): 1239-1240 (letter)
4. Rubin, B.S., Dube, A.H., Mitchell, E.K. Asphyxial deaths due to physical restraint. A case series. Arch. Fam. Med. 1993 Apr.; 2 (4):405-408.
5. Hick, J.L., Smith,S.W., Lynch, M.T. Metabolic acidosis in restraint-associated cardiac arrest: a case series. Acad. Emerg. Med. 1999 Mar; 6(3):239-43.
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7. Ontario Association of Children's Aid Societies Journal. June 2003; 47(1).

Children's Aid Involvement: Background

As mentioned earlier in the report, the Paediatric Death Review Committee has been reviewing the deaths of all children in the province who were receiving child welfare services at the time of their death. The PDRC also reviews deaths where the child had received service from a CAS in the 12 months preceding the death and when there are questionable circumstances surrounding the death such as evidence of abuse, neglect etc.

In 1999, the PDRC reviewed 58 cases where the child had some involvement with a CAS at the time of the child's death. During the year 2000, 46 such deaths were reviewed.

The PDRC has also remarked on excellent practice, dedicated staff and work undertaken in less than ideal circumstances.

The PDRC reports, which often include recommendations, are sent to the Executive Directors of the CAS agency involved with the child, as well as the Assistant Deputy Minister, Ministry of Community and Social Services (MCSS). Feedback to the PDRC recommendations are encouraged and responses are often received by the PDRC from both the MCSS and the various CAS's.

The Ministry of Community and Social Services (MCSS), the Ontario Association of Children's Aid Societies (OACAS) and the Office of the Chief Coroner have, over the past few years, been providing guidance in response to the heightened sensitivity and growing concern about the deaths of children in Ontario.

In 1995, the MCSS issued a Directive which required all Regional Offices and Children's Aid Societies (CAS) to complete reviews of all cases in which children died as a result of abuse or under questionable circumstances while receiving service from a CAS. Since then the MCSS, CAS and the Paediatric Death Review Committee of the Office of the Chief Coroner have conducted such reviews.

In 1996, the Office of the Chief Coroner, the OACAS and the MCSS established the Child Mortality Task Force which reviewed deaths of children who died while receiving service from a CAS between January 1994 and December 1995. As a result of a number of inquests held in 1997 and 1998, and through the Child Mortality Task Force, several recommendations were made regarding the need for clarification and streamlining of current procedures for child death reporting and reviews.

In September 2000, a Joint Directive between the Ministry of Community and Social Services and the Office of the Chief Coroner was adopted. The goal of this Directive is to clarify procedures and protocols for the child death reporting and review process. It also satisfies a number of other objectives for each sector. Further information regarding this Directive can be obtained from the MCSS, Management Support Branch or from the Office of the Chief Coroner.

As previously detailed in this report, in 2002, 32 cases involving child welfare services were reviewed by the PDRC, and 28 cases in 2003 have been reviewed, resulting in numerous recommendations being made for the improvement of services to children in need of protection.

Case Reviews Involving Children's Aid Agencies: THEMES

Similar to medical case reviews, the Paediatric Death Review Committee has noted themes arising in their review of child welfare cases. The following highlights themes seen by the PDRC over the years.

Gaps in Service/Points of Vulnerability

- Worker absence
- Supervisor absence
- Weekend phenomenon/After-hours coverage
- Internal transfers, interagency transfers of cases
- Interagency coordination/communication
- Premature case closings
- Variable response to re-openings
- Lack of follow-up services

Pattern of Parental Neglect

- Most prevalent contributing factor in PDRC reviews
- Failure to consider, or tendency to, minimize past history
- Failure to verify, or minimal effort to verify, information
- Treating multiple openings as a series of discrete events
- Limited knowledge of signs, effects and dynamics of neglect

Variable Use of the Courts

- To enforce or motivate difficult clients

Over Representation of Aboriginal Children

- High suicide rate
- Lack of services in Aboriginal communities

Use of Restraints in Residential Settings

- Mandatory training requirements in place
- Underlying issues need to be addressed

High Risk Cases

Need identified for improving the frequency and quality of parenting capacity assessments.

Need identified for enhanced training, consultation, and protocols for:

- Failure to thrive, healthy infant development
- Substance abuse
- Mental illness
- Chronic neglect
- Suicidal ideation
- Young parents with limited parenting skills
- Angry/violent/resistant clients
- Monitoring of such high-risk cases

Documentation

- Records should focus more on history and completion of a coherent and comprehensive child welfare assessment
- Family file records should focus more on child's needs and functioning
- IFRS documentation system does not facilitate preceding objectives

The Committee has also identified many examples of exemplary practice, such as the use of frequent conferencing, clear and frequent communication with collaterals, clear and comprehensive record keeping, including responsibilities of service partners and of service objectives. Agencies have frequently been commended for the high quality of care provided by foster parents, to children with special needs.

Summary

In 1997, the Paediatric Death Review Committee expanded its mandate to review the deaths of children who were receiving services from a Children's Aid Agency at the time of their death. During that period, significant changes have been made to provincial child welfare legislation, child protection practice and the funding of Children's Aid Societies. All of this has occurred in the sometimes harsh glare of inquests and public scrutiny of child welfare practices. The events experienced in Ontario have been played out in other jurisdictions as the public has increasingly demanded accountability for the services delivered to vulnerable children.

It is important to note that while reviewing cases, the Committee has also seen excellent practice for which the field is to be commended. We have seen examples of excellent documentation and thorough assessments of risk and parenting capacity; thorough cases reviews; and, excellent collaboration with police and other service providers.

Our system will never be completely successful in identifying risks and preventing harm to children. We believe, however, that reviews such as those conducted by the Committee serve as a reminder of the vulnerability of children and the need for vigilance.

Future Directions

The following points highlight areas for consideration to improve the child death review process in the Province of Ontario:

- Increase number of child welfare experts on the Paediatric Death Review Committee to assist in review of CAS cases
- Production of annual report on the activities of the Paediatric Death Review Committee
- Review of Death Review Protocol for Child Welfare Cases by the Ministry of Children and Youth Services (MCYS), OACAS, and the Office of the Chief Coroner
- Development of Internal Death Review Protocol for Children's Aid Societies in Ontario (Task Force launched by OACAS)
- Research possible development of database and tracking system for PDRC cases
- Improved cooperation between the Office of the Chief Coroner and MCYS to verify data on child deaths in the province
- Improved resourcing of PDRC process
- Increase frequency of Coroner's Regional Case Conferences to engage service providers to review PDRC findings
- Encourage a blame free learning environment to reduce errors and omissions

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Reference Materials

<u>Websites</u>:

Office of the Chief Coroner
www.mpss.jus.gov.on.ca/english/pub_safety/office_coroner/about_coroner.html

AAP (American Academy of Pediatrics)
www.aap.org

OACAS (Ontario Association of Children's Aid Societies)
www.oacas.org

SIDS Foundation of Canada
www.sidscanada.org

Canadian Pediatric Society
www.cps.ca

National Association of Medical Examiners
www.thename.org/Library/MannerRev.pdf

<u>Journal Articles:</u>
Coroners Corner Articles written by the Paediatric Death Review Committee are published periodically in the *Journal of Pediatrics and Child Health* (www.cps.ca) - Most recent publications appear in the 2004 issues on ***Death related to restraint*** and ***Abdominal pain, vomiting and tachycardia.***

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