Table of Contents

Table of Contents ................................................................................................................................. 1
Message from the Chair ............................................................................................................................ 3
The Office of the Chief Coroner and the Context of Paediatric Deaths in Ontario ................................. 5
Child and Youth Deaths in Ontario and Canada: Trends Over Time .................................................... 6
Deaths Under Five Committee .................................................................................................................. 11
DUSC cases reviewed in 2016 .................................................................................................................. 13
DUSC cases reviewed in 2017 .................................................................................................................. 14
Determining the Cause and Manner of Death ....................................................................................... 18
Deaths Under Five Committee Classification of Infant Deaths ................................................................ 21
Paediatric Death Review Committee – Medical ...................................................................................... 30
Analysis of 2016 and 2017 Case Reviews PDRC – Medical ................................................................. 31
Recommendations ................................................................................................................................... 32
PDRC – Medical: Case Example .......................................................................................................... 34
Paediatric Death Review Committee – Child Welfare ............................................................................ 38
Use of data by the PDRC – Child Welfare ............................................................................................ 39
PDRC – Child Welfare’s Approach to Statistical Analysis ..................................................................... 40
Looking forward: Data-Driven Death Review ....................................................................................... 40
2016 and 2017 Paediatric Deaths with Society Involvement Compared to Other Paediatric Deaths in Ontario ........................................................................................................................................ 41
Coroner’s Cases with Society Involvement Compared with Coroner’s Cases without Society Involvement – Gender and Age ........................................................................................................ 42
Manner of Death – Coroner’s Cases with Society Involvement Compared with Coroner’s Cases without Society Involvement ........................................................................................................ 46
What do we know about deaths where the manner of death is undetermined? .................................. 49
2016 and 2017 Deaths with Society Involvement – Status of Children and Youth .................................. 51
Deaths of Indigenous Children and Youth with Children’s Aid Society Involvement Investigated by the Office of the Chief Coroner in 2016 and 2017 ........................................................................... 56
Message from the Chair

There have been a number of achievements made over the past two years in advancing child death investigation and review. This area continues to be one of the most important and challenging parts of our mandate. The Paediatric Death Review Committee (PDRC) and Deaths Under Five Committee (DU5C) exist to help us learn from child deaths in order to help prevent further deaths. Each opportunity to learn offers an important opportunity to reduce child mortality - potentially sparing the profound grief families suffer when a young life full of promise is lost prematurely.

Enhancing these opportunities to learn is a priority for the Office of the Chief Coroner (OCC) and for others. Since 2014, we have been working with the Ministry of Children, Community and Social Services (MCCSS), formerly known as the Ministry of Children and Youth Services (MCYS) and the Office of the Ontario Child Advocate (OCA) to develop a “best-in-class” model of review that will be data-driven, evidence informed and grounded in collaborative partnerships. This will maximize the potential for affecting public health analysis, policy development, research and prevention strategies in the province of Ontario.

The Child and Youth Death Review and Analysis Team (CYDRA) has been operational since December 2017 and has been granted two year-funding through a tripartite agreement between the Office of the Chief Coroner, the Ontario Child Advocate and the MCCSS.

Recognizing that death prevention is a shared responsibility and that children, youth and families are impacted by multiple systems, the new model will incorporate multiple organizations at various levels to thoroughly inform the death investigation and review process at each stage. With broader input and participation, there will be increased opportunity for timely, relevant learning, and more comprehensive data will be available to inform surveillance and help to identify trends and themes that can point to systemic issues. This is key to determining the right areas for targeting further analysis, prevention strategies and areas where research could be of benefit.

We are in the process of developing a pilot project, and expect to be engaging with our community members on this topic in 2019.

While the new model is under development, the PDRC and DU5C have continued their valuable work. Their thoughtful analysis continues to identify important recommendations that can make a significant contribution to community safety and are instrumental in bringing preventative strategies to the attention of organizations. I am grateful for the hard work of the committee members and their ongoing commitment to child death review. Their work is well documented in this annual report.
I am pleased to report that Jessica Diamond, who held the Executive Lead, Child Welfare position and completed the foundational work to inform the new CYDRA approach, has become Manager, Children in Care at MCCSS. We congratulate Jessica and thank her for all the commitment, leadership and hard work during her time with the OCC. We are pleased that Peggy McPhail joined our organization shortly after Jessica’s departure. Peggy has hit the road running!

I look forward to continued work with others toward the shared goal of improving the health, safety and well-being of Ontario’s children and youth.

Dirk Huyer, MD
Chief Coroner for Ontario
Chair, Paediatric Death Review Committee and Deaths Under Five Committee
The Office of the Chief Coroner and the Context of Paediatric Deaths in Ontario

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

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

In Ontario, coroners are medical doctors with training in the principles of death investigation. Coroners investigate approximately 17,000 deaths per year in accordance with Section 10 of the Coroners Act. They investigate all non-natural deaths such as those involving violence, foul play, suicide, and where accidental injury may be involved. Investigations are completed on natural deaths that are sudden and unexpected as the manner of death is initially unclear. Other natural death investigations may occur depending on the type of death and/or if there are concerns about the care of the deceased prior to death. The OCC applies the following definitions when determining the manner of death:

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

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

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

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

**Undetermined:** a death is classified as undetermined when a full investigation has not demonstrated adequate evidence for a specific classification or there is equal evidence or a significant contest among two or more manners of death.

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

The Paediatric Death Review Committee (PDRC) and the Deaths Under Five Committee (DUSC) are two of the seven expert death review committees that report to the Chief Coroner for Ontario. For administrative purposes, the PDRC is composed of two sections based on the nature and circumstances of the death: PDRC - Child Welfare reviews cases with involvement of a children’s aid society or Indigenous child wellbeing society, and PDRC - Medical reviews the deaths of children where issues or concerns about the medical diagnosis or provision of care have been identified.
The OCC has death investigation procedures that mandate expert death committee reviews for deaths in certain circumstances. The DUSC reviews all deaths investigated by coroners involving children under the age of five. The PDRC - Child Welfare must review all deaths involving children and youth when the child, the youth or their family was receiving, or had received, the services of a children’s aid society or Indigenous child wellbeing society (“Society”) within 12 months of the death. All other reviews conducted by the PDRC, particularly those with medical implications, are done on a discretionary basis and are referred to the PDRC – Medical by the relevant Regional Supervising Coroner or DUSC.

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

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

While the OCC defines the paediatric age group from live birth to the nineteenth birthday, adolescent data provided by Statistics Canada also includes the nineteenth year (i.e. up to the twentieth birthday). For the purpose of the comparisons demonstrated in Charts 1 – 4, data from the OCC includes investigations of adolescent deaths up until the twentieth birthday as well. On average, the OCC investigates 63 deaths of individuals in their nineteenth year. For Charts 1 – 4, please note that 2016 is the most recent year for which complete data is available nationally.

Chart 1 illustrates the number of child and youth deaths per year and compares the number of cases investigated by the OCC with the provincial and national numbers. Between 2005 and 2016 the year to year totals have remained fairly consistent.

Chart 1: Comparison of Child and Youth Deaths in Canada and Ontario with Ontario Coroner’s Cases 0-19 Years of Age (2005-2016)
Chart 2: Paediatric population vs. paediatric deaths in Ontario compared with Canadian totals

Chart 2 provides the actual numbers of child and youth deaths per year and shows the percentage of paediatric deaths in Ontario as a proportion of the national total. Between 2005 and 2016, the year to year totals have remained fairly consistent.

<table>
<thead>
<tr>
<th>Year</th>
<th>Paediatric Population – Canada (Total)</th>
<th>Paediatric Population – Ontario (Total)</th>
<th>% of Ontario paediatric population vs. Canada</th>
<th>Paediatric Deaths - Canada (Total)</th>
<th>Paediatric Deaths - Ontario (Total)</th>
<th>% of Ontario paediatric deaths vs. Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>7,874,686</td>
<td>3,129,130</td>
<td>40%</td>
<td>3640</td>
<td>1335</td>
<td>37%</td>
</tr>
<tr>
<td>2006</td>
<td>7,865,435</td>
<td>3,127,664</td>
<td>40%</td>
<td>3513</td>
<td>1249</td>
<td>36%</td>
</tr>
<tr>
<td>2007</td>
<td>7,859,930</td>
<td>3,116,390</td>
<td>40%</td>
<td>3591</td>
<td>1297</td>
<td>36%</td>
</tr>
<tr>
<td>2008</td>
<td>7,869,257</td>
<td>3,112,369</td>
<td>40%</td>
<td>3517</td>
<td>1237</td>
<td>35%</td>
</tr>
<tr>
<td>2009</td>
<td>7,867,349</td>
<td>3,101,042</td>
<td>39%</td>
<td>3423</td>
<td>1247</td>
<td>36%</td>
</tr>
<tr>
<td>2010</td>
<td>7,850,628</td>
<td>3,087,884</td>
<td>39%</td>
<td>3424</td>
<td>1201</td>
<td>35%</td>
</tr>
<tr>
<td>2011</td>
<td>7,833,278</td>
<td>3,074,838</td>
<td>39%</td>
<td>3245</td>
<td>1122</td>
<td>35%</td>
</tr>
<tr>
<td>2012</td>
<td>7,828,135</td>
<td>3,062,498</td>
<td>39%</td>
<td>3247</td>
<td>1166</td>
<td>36%</td>
</tr>
<tr>
<td>2013</td>
<td>7,848,394</td>
<td>3,069,969</td>
<td>39%</td>
<td>3295</td>
<td>1157</td>
<td>35%</td>
</tr>
<tr>
<td>2014</td>
<td>7,843,048</td>
<td>3,051,984</td>
<td>39%</td>
<td>3135</td>
<td>1092</td>
<td>35%</td>
</tr>
<tr>
<td>2015</td>
<td>7,838,448</td>
<td>3,034,963</td>
<td>39%</td>
<td>3112</td>
<td>1086</td>
<td>35%</td>
</tr>
<tr>
<td>2016</td>
<td>7,879,910</td>
<td>3,043,712</td>
<td>39%</td>
<td>3120</td>
<td>1134</td>
<td>36%</td>
</tr>
<tr>
<td>Average</td>
<td>7,854,875</td>
<td>3,084,370</td>
<td></td>
<td>3355</td>
<td>1194</td>
<td></td>
</tr>
</tbody>
</table>

Child and Youth Deaths in Ontario: Distribution Across Age Groups

Charts 3A and 3B illustrate the number of death investigations completed by the OCC compared with the total number of Ontario deaths in 2016 and 2017, distributed by age group. Proportionately, infants compose the largest subgroup of deaths, followed by adolescents.
Chart 3A: Distribution of Paediatric Deaths Across Age Groups (2016)

Chart 3B: Distribution of Paediatric Deaths Across Age Groups (2017)

Chart 4A illustrates that in 2016, the OCC investigated approximately 21% of infant deaths (< 1 year), 63% of deaths of 1-4 year olds, 51% of the 5-9 year olds, 59% of 10-14 year olds and 79% of adolescent deaths (15-19 year olds).
Chart 4B illustrates that in 2017, the OCC investigated approximately 18% of infant deaths (< 1 year), 70% of deaths of 1-4 year olds, 55% of the 5-9 year olds, 78% of 10-14 year olds and 90% of adolescent deaths (15-19 year olds).
Charts 5A and 5B illustrate the manners of paediatric deaths investigated by a coroner in 2016 and 2017. The charts demonstrate that there is a change in the distribution of the manner of death provided by Ontario coroners that follows age progression from infancy to adolescence. Natural and undetermined deaths dominate investigations of children under one, gradually changing to non-natural manners (accident, homicide and suicide) which are more prevalent among adolescents.


![Chart 5A - Manner of Death in OCC investigations Distribution across age groups (2016)](image)

Chart 5B: Manner of Death in OCC Investigations – Distribution across age groups (2017)

![Chart 5B - Manner of Death in OCC investigations Distribution across age groups (2017)](image)
Deaths Under Five Committee

Introduction

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

Scope and Mandate

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

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

DU5 Review Process

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

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

Executive Team

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

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

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

**Full Committee**

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

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

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

- Post mortem examination, toxicology results and other investigative findings
- Photographs (of the scene and post mortem examination)
- Coroner’s Investigation Statement
- Investigation Questionnaire for Sudden and Unexpected Deaths in Infants
- Police and other investigative reports (e.g. Fire Marshal and children’s aid society/Indigenous child wellbeing society reports, etc.)

Chart 6 Illustrates that over the past seven years, the full DU5C reviewed between 55 and 108 cases. The manner of death for the majority of cases was “undetermined.”
DU5C cases reviewed in 2016

Summary of Full DU5C Reviews in 2016:
In 2016, the full DU5C reviewed 61 cases.
- Of the cases reviewed by full DU5C, 59% (36) involved male children and 41% (25) female children.
- Of the cases reviewed by the full DU5C, the manner of death was 95% (58) undetermined, 3% (2) natural and 1.5% (1) accident.
- Of the cases reviewed by the full DU5C, 79% (48) involved children less than one year old.
- Of the cases reviewed by the full DU5C, 21% (13) involved children aged one to five years.
- Of the cases reviewed by the full DU5C involving children less than one year, the manner of death was 2% (1) natural, 2% (1) accident and 96% (46) undetermined.
- Of the cases reviewed by the full DU5C involving children aged one to five years, the manner of death was 8% (1) natural, and 92% (12) undetermined.

Cases reviewed by the Full DU5C involved deaths that occurred in 2012 (2), 2013 (1), 2014 (6), 2015 (44) and 2016 (8).

Summary of Executive Reviews in 2016:
In 2016, the executive team reviewed 85 cases.
- Of the cases reviewed by the executive team, 58% (49) involved male children and 42% (36) female children.
- Of the cases reviewed by the executive team, 53% (45) involved children less than one year old.
- Of the executive reviews involving children less than one year, the manner of death was 84% (38) natural, 4% (2) homicide, 4% (2) undetermined and 7% (3) accident.
- Of the cases reviewed by the executive team, 47% (40) involved children aged one to five years.
- Of the executive reviews involving children aged one to five years, the manner of death was 53% (21) natural, 38% (15) accident, 3% (1) undetermined and 78% (3) homicide.

Collectively, for all executive team reviews, the manner of death was 69% (59) natural, 21% (18) accident, 6% (5) homicides and 4% (3) undetermined deaths.

Cases reviewed by the executive team involved deaths that occurred in 2013 (3), 2014 (3), 2015 (45) and 2016 (34).
Total Cases Reviewed by the DU5C (Executive Team + Full Committee) in 2016:
In 2016, there were 85 cases reviewed by the executive team and 61 cases reviewed by the full DU5C, for a combined total of 146 cases.
Of all cases reviewed by the executive team and full DU5C, 58% (85) involved male children and 42% (61) female children.
Collectively, for all executive team and full DU5C reviews, the manner of death was 42% (61) natural, 13% (19) accident, 3% (5) homicide and 42% (61) undetermined.
Of the cases reviewed by the executive team and full DU5C, 90% (131) involved deaths that occurred in 2015 and 2016.

DU5C cases reviewed in 2017

Summary of Full DU5C Reviews in 2017:
In 2017, the full DU5C reviewed 57 cases.
Of the cases reviewed by full DU5C, 63% (36) involved male children and 37% (21) female children.
Of the cases reviewed by the full DU5C, the manner of death was 89% (51) undetermined, 7% (4) natural and 4% (2) accident.
Of the cases reviewed by the full DU5C, 89% (51) involved children less than one year old.
Of the cases reviewed by the full DU5C, 11% (6) involved children aged one to five years.
Of the cases reviewed by the full DU5C involving children less than one year, the manner of death was 6% (3) natural, 4% (2) accident and 90% (46) undetermined.
Of the cases reviewed by the full DU5C involving children aged one to five years, the manner of death was 17% (1) natural, and 87% (5) undetermined.
Cases reviewed by the Full DU5C in 2017 involved deaths that occurred in 2014 (2), 2015 (7), 2016 (40) and 2017 (8).

Summary of Executive Reviews in 2017:
In 2017, the executive team reviewed 66 cases.
Of the cases reviewed by the executive team, 58% (38) involved male children and 42% (28) female children.
Of the cases reviewed by the executive team, 46% (30) involved children less than one year old.
Of the executive reviews involving children less than one year, the manner of death was 80% (24) natural, 7% (2) undetermined, 13% (4) accident and no homicides.
Of the cases reviewed by the executive team, 55% (36) involved children aged one to five years.
Of the executive reviews involving children aged one to five years, the manner of death was 47% (17) natural, 42% (15) accident, 6% (2) undetermined and 6% (2) homicide.
Collectively, for all executive team reviews, the manner of death was 62% (41) natural, 29% (19) accident, 3% (2) homicides and 6% (4) undetermined deaths.
Cases reviewed by the executive team involved deaths that occurred in 2013 (1), 2014 (1), 2015 (5), 2016 (38) and 2017 (21).
**Total Cases Reviewed by the DU5C (Executive Team + Full Committee) in 2017:**

In 2017, there were 66 cases reviewed by the executive team and 57 cases reviewed by the full DU5C, for a combined total of 123 cases.

Of all cases reviewed by the executive team and full DU5C, 60% (74) involved male children and 40% (49) female children.

Collectively, for all executive team and full DU5C reviews, the manner of death was 37% (45) natural, 17% (21) accident, 2% (2) homicide and 45% (55) undetermined.

Of the cases reviewed by the executive team and full DU5C in 2017, 87% (107) involved deaths that occurred in 2016 and 2017.

**Analysis of findings:**

Charts 7A and 7B demonstrate the difference in findings of manner of death between cases reviewed by the executive and full DU5C reviews in 2016 and 2017. The majority of executive reviews involved natural deaths. The majority of full DU5C reviews involved deaths where the manner was undetermined.

**Chart 7A: Manner of Death – Executive vs. Full DU5 Reviews (2016) (n=146)**
Charts 8A and 8B demonstrate the manner of death categorized by age for both the executive and full DU5C in 2016 and 2017. The majority of executive reviews of natural deaths involved children less than one year old. The majority of full DU5C reviews of undetermined deaths involved children less than one year old.

Chart 8A: Manner of Death based on age (<1yr vs. 1-5 yrs) and level of review (Executive vs. Full DU5 Committee) – 2016 (n=146)
Chart 8B: Manner of Death based on age (<1yr vs. 1-5 yrs) and level of review (Executive vs. Full DUS Committee) – 2017 (n=123)

Chart 9A demonstrates that 34% of all DUSC referrals in 2016 came from Central Region, 29% of referrals came from West Region, 27% of referrals came from the East Region and 10% of referrals came from the North Region.1

Chart 9A: % of Total DU5 Reviews based on Region (2016) (n=146)

---

1 Based on regional boundaries of the Office of the Chief Coroner (2015)
Chart 9B: % of Total DU5 Reviews based on Region (2017) (n=123)

Chart 9B demonstrates that 34% of all DU5C referrals in 2017 came from Central Region, 37% of referrals came from West Region, 15% of referrals came from the East Region and 14% of referrals came from the North Region.

Determining the Cause and Manner of Death

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

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

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

In recent years molecular testing has not been completed in all cases of sudden and unexpected infant death. While testing was considered in unexpected infant deaths, there was concern that if testing identified abnormalities of unknown significance relating to the death, reporting the abnormality could lead to undue
concern for surviving and future family members. It was felt that clinicians were in the best position, based upon their clinical assessment of family members, to determine the most appropriate testing.

There have been significant advances in the area of molecular testing over recent years including in the area of unexpected infant deaths. Ontario’s death investigation system has continued to work closely with paediatric cardiologists and geneticists who have expertise in evaluating heritable cardiac abnormalities. Consultation with these experts has informed the development of a protocol for molecular testing in all cases of unexpected infant deaths where the post mortem examination has not identified a cause of death.

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

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

Chart 10 identifies the criteria used for classifying infant deaths in Ontario.

**Chart 10: Infant Death Classification**

<table>
<thead>
<tr>
<th>Autopsy Findings</th>
<th>Investigative Findings</th>
<th>Cause of Death on Death Certificate</th>
<th>Manner of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Autopsy reveals a definitive cause of death (pneumonia, head injury, etc.) that informs a definitive manner of death</td>
<td>Variable/may directly inform cause/manner of death</td>
<td>As per the autopsy/investigative findings</td>
</tr>
<tr>
<td>2*</td>
<td>No anatomic or toxicological cause of death identified</td>
<td>No findings of concern identified during the complete investigation -child found supine or prone -no evidence of sleep-associated circumstances** -may include exposure to environmental tobacco smoke or in utero tobacco use</td>
<td>1a- Sudden Infant Death Syndrome (SIDS)</td>
</tr>
<tr>
<td>Autopsy Findings</td>
<td>Investigative Findings</td>
<td>Cause of Death on Death Certificate</td>
<td>Manner of Death</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------</td>
<td>------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>3A No anatomic or toxicologic cause of death identified</td>
<td>Presence of sleep associated circumstances ** Presence or absence of social risk factors ***</td>
<td>Ia- Undetermined Ib- II-Unsafe Sleep Environment (description in parentheses)</td>
<td>Undetermined</td>
</tr>
<tr>
<td>3B No anatomic or toxicologic cause of death identified</td>
<td>Includes cases that do not meet definition of SIDS No sleep associated circumstances** May be presence of social risk factors ***</td>
<td>Ia- Undetermined Ib- II-</td>
<td>Undetermined</td>
</tr>
<tr>
<td>4 No anatomic or toxicologic cause of death identified</td>
<td>Findings in investigation/ autopsy, examples include: - autopsy findings for which the differential diagnosis includes non-accidental injury (eg: healing fracture, bruises, etc.) -death of a previous child in suspicious circumstances -significant toxicologic findings for which there is an inadequate explanation</td>
<td>Ia- Undetermined Ib- II-</td>
<td>Undetermined</td>
</tr>
</tbody>
</table>

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

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

* Category 2 represents deaths that meet the definition of Sudden Infant Death Syndrome (SIDS)

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

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

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

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

A death would be considered as Category 4 if:

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

**Deaths Under Five Committee Classification of Infant Deaths**

**2016 findings:**

In 2016, 64% (93 of 146) of the deaths reviewed by the DU5C occurred in infants who were less than one year of age. Chart 11A provides the classification of Infant deaths reviewed by the Deaths Under Five Committee in 2016.
<table>
<thead>
<tr>
<th></th>
<th>Autopsy findings</th>
<th>Investigative Findings</th>
<th>Environment</th>
<th># of 2016 DU5 Cases (Executive + Full Cmt) involving infants under age 1 year</th>
<th>% of total DU5C Reviews involving infants under age 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Autopsy reveals a definitive cause of death (e.g. pneumonia, head injury, etc.) that informs a definitive manner of death</td>
<td>Variable/may directly inform cause/manner of death.</td>
<td>Natural Accident (with unsafe sleep environment)</td>
<td>40</td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Accident</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Homicide</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No Anatomic or toxicologic cause of death identified</td>
<td>No findings of concern identified during the complete investigation</td>
<td>Natural - SIDS</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✦ child found supine or prone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>✦ no evidence of sleep-associated circumstances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>✦ may include exposure to environmental tobacco smoke or utero tobacco use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A</td>
<td>No Anatomic or toxicologic cause of death identified</td>
<td>Presence of sleep associated circumstances and/or presence or absence of social risk factors</td>
<td>Undetermined (unsafe sleep circumstances)</td>
<td>42</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Unsafe sleeping environment (other)</td>
<td>(23)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Bedsharing</td>
<td>(19)</td>
<td></td>
</tr>
</tbody>
</table>
### Autopsy findings | Investigative Findings | Environment | # of 2016 DU5 Cases (Executive + Full Cmt) involving infants under age 1 year | % of total DU5C Reviews involving infants under age 1 year
---|---|---|---|---
3B | No Anatomic or toxicologic cause of death identified | Include cases that do not meet definition of SIDS. No sleep associated circumstances. May be presence of social risk factors. | Undetermined | 2 | 2%

4 | No Anatomic or toxicologic cause of death identified | Findings in investigation/autopsy, examples include: Healing fracture, bruises, etc. Death of a previous child in suspicious circumstances Significant toxicologic findings for which there is inadequate explanation | Undetermined - no explanation | 3 | 3%

| | | | Total | 93 |

### 2017 findings:

In 2017, 66% (81 of 123) of the deaths reviewed by the DU5C occurred in infants who were less than one year of age. Chart 11B provides the classification of Infant deaths reviewed by the Deaths Under Five Committee in 2017.
**Chart 11B: Classification of infant deaths (under age 1 year) reviewed by the Deaths Under Five Committee in 2017**

<table>
<thead>
<tr>
<th>Autopsy findings</th>
<th>Investigative Findings</th>
<th>Environment</th>
<th># of 2017 DU5 Cases (Executive + Full Cmt) involving infants under age 1 year</th>
<th>% of total DU5C Reviews involving infants under age 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Autopsy reveals a definitive cause of death (e.g. pneumonia, head injury, etc.) that informs a definitive manner of death</td>
<td>Variable/may directly inform cause/manner of death.</td>
<td>Natural Accident (with unsafe sleep environment)</td>
<td>27</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accident</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homicide</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
<td></td>
</tr>
<tr>
<td>2 No Anatomic or toxicologic cause of death identified</td>
<td>No findings of concern identified during the complete investigation</td>
<td>Natural - SIDS</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>➢ child found supine or prone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ no evidence of sleep-associated circumstances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ may include exposure to environmental tobacco smoke or utero tobacco use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A No Anatomic or toxicologic cause of death identified</td>
<td>Presence of sleep associated circumstances and/or presence or absence of social risk factors</td>
<td>Undetermined (unsafe sleep circumstances)</td>
<td>36</td>
<td>44%</td>
</tr>
<tr>
<td></td>
<td>➢ Unsafe sleeping environment (other)</td>
<td></td>
<td>(26)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Bedsharing</td>
<td></td>
<td>(13)</td>
<td></td>
</tr>
</tbody>
</table>
The Importance of Consistent Definitions

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

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

**Sudden Infant Death Syndrome (SIDS)**

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

In Ontario, a death will be attributed to SIDS following a thorough review of all components of the death investigation including: the autopsy; examination of the death scene; review of the clinical history; and a review of the police investigation. The death is then reviewed by the DU5C, who will only attribute the death to SIDS if a consensus decision is reached that the case strictly meets the definition. The DU5C strictly applies the definition of SIDS and excludes cases with even minor deviations. SIDS is only given as a cause of death when all other causes have been ruled out. If the investigation reveals any concerning finding, the cause of death will not be classified as SIDS. It is a finding of exclusion, which is why there were no SIDS cases in 2016 or 2017.

**Understanding the Manner of Death**

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

In 50% (47 out of 93 - see data in Chart 11A – Sections 3A+3B+4) of infant deaths reviewed in 2016 by DU5C, the manner of death was “undetermined.” Undetermined is one of four potential manners of death that would apply in infancy.

In 59% (48 out of 81 - see data in Chart 11B – Sections 3A+3B+4) of infant deaths reviewed in 2017 by DU5C, the manner of death was “undetermined.”

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

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

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

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

**Undetermined**: a full investigation has shown no evidence for any specific classification or there is equal evidence or a significant contest among two or more manners of death.
The manner of death is informed by the autopsy and other investigative findings. At times, the external and internal examinations completed at the time of autopsy do not reveal an anatomic cause of death. This is more common for infant deaths than youth or adult cases.

A so-called “negative autopsy” may present in a number of situations including, but not limited to:
- Toxicologic deaths
- Metabolic disorders
- Asphyxial deaths (e.g. airway obstruction)
- Infectious disease
- Cardiac diseases (e.g. conduction disorders)
- Sudden Infant Death Syndrome (SIDS)

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

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

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

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

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

**Unsafe Sleep Circumstances - Determining the Role**

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

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

Capturing Factors Potentially Related to the Death

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

Triple Risk Model to Explain SIDS

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

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

The DU5C considers the potential contribution of sleep related circumstances within the context of stratification of risk (based upon literature and experience). During case review by the DU5C, unsafe sleep circumstances found at the death scene preclude the death from being classified as SIDS. Any factor identified at the death scene which might interfere with an infant’s breathing and/or cause entrapment, overlaying, or

suffocation is identified. These include: sharing a sleep surface; unsafe sleep surfaces (not intended for infant sleep) such as adult mattresses, waterbeds, couches, car carriers, car seats; a safe sleep surface which is cluttered with toys, blankets and pillows; or a non-approved bassinet or playpen. This is in contrast to previous literature and the practices of some jurisdictions, where these deaths are classified as SIDS.

The association between unsafe sleep environments and sudden unexpected infant deaths has been recognized by death investigators and researchers for many years. The literature, including a number of recent publications, adds to the growing field of knowledge about infant deaths. Two articles of interest are: Sleep Environment Risks for Younger and Older Infants (Colvin, JD, Collie-Akers V, Schunn C, et al. Pediatrics 2014; 134: e406-e412); and the Registered Nurses’ Association of Ontario Working with Families to Promote Safe Sleep for Infants 0-12 months of age. The American Academy of Pediatrics released updated recommendations for a safe infant sleep environment: SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. Pediatrics. 2016; 138(5):e20162938

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

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

Unsafe Sleep Environment – What is the data?

Review of Charts 11A and 11B demonstrates that there were 47 infant deaths reviewed by the DU5C in 2016 and 48 in 2017 where the manner was deemed to be undetermined (Categories 3A + 3B +4). There were 42 infant deaths in 2016 and 36 in 2017 classified as 3A (unsafe sleep circumstances) indicating that sleep circumstances may have been a contributing factor.
Paediatric Death Review Committee – Medical

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

Medical reviews analyze and consider the medical issues involved in the time preceding a child’s death to gain a better understanding of the circumstances of the death. Case referrals for committee evaluation include medically complex deaths when there are concerns regarding the medical care or if 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. Similarly, the death of a neonate will be primarily reviewed by the neonatologist. The review process involves analyzing the existing record of the decedent. The record routinely includes medical records, the Coroner’s Investigation Statement, the report of the post mortem examination, toxicology report, police report and other relevant documents.

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

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

Limitations

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

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

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

Statistical Analysis for Paediatric Death Review Committee – Medical

The number of PDRC – Medical reviews varies from year to year. Chart 12 illustrates the number of PDRC - Medical reviews from 2004 to 2017. In 2016, there were nine reviews and in 2017, there were five reviews.

Chart 12: PDRC (medical) – Total number of reviews (2004-2017)

Analysis of 2016 and 2017 Case Reviews PDRC – Medical

In 2016, there were nine cases reviewed by the PDRC – Medical and in 2017, there were five cases reviewed.

Of the cases reviewed in 2016, seven involved children under one year of age, two involved children aged one to four years, and none involved children aged five or older. Of the nine cases reviewed, three were male and six were female.

Of the cases reviewed in 2017, four involved children under one year of age and one involved a child aged one to four years. Of the five cases reviewed, three were female and two were male.
Recommendations

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

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

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

In 2016, the nine reviews resulted in 18 recommendations. There was one case that resulted in no recommendations.

In 2017, the five reviews resulted in 12 recommendations. There was one case that resulted in no recommendations.

**Summary of 2016-2017 recommendations made by PDRC – Medical**

The recommendations made from the PDRC – Medical reviews in 2016-2017 focused on the following themes and were addressed to the identified organizations:

<table>
<thead>
<tr>
<th>Organization(s) asked to respond to recommendation</th>
<th>Theme of recommendation(s)</th>
<th>Number of reviews where theme was identified 2016</th>
<th>Number of reviews where theme was identified 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care organizations Treating Health Care Professionals</td>
<td>Quality of Care</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Health care organizations Treating Health Care Professionals</td>
<td>Differential diagnosis</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Health care organizations</td>
<td>Communication</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Health care organizations</td>
<td>Documentation</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Health care organizations</td>
<td>Transport</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Some cases resulted in multiple recommendations touching on different themes.
Themes arising during medical reviews

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

Themes from 2016 and 2017 case reviews

The cases reviewed by the PDRC – Medical in 2016 and 2017 were associated with four 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:

**Treatment - Quality of Care**

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

- Emergency room protocols and procedures;
- Recognition, assessment and management of seriously ill high risk children;
- Airway management in a child who had serious respiratory illness;
- Assessment and care of a child during the Paediatric Intensive Care Unit admission;
- Importance of cultural awareness to ensure effective and culturally informed intersections of health care providers with families;
- Development of protocols that clarify and separate clinical care discussions such as withdrawal of life support from discussion about consent for organ and tissue donation;
- Clarity around staff supervision in surgery, neonatology and radiology;
- Inotropic support and fluid administration in the care of infants in cardiogenic shock;
- Protocols and guidelines for staff physicians responsible for monitoring and overseeing medical students;
- Policies for ensuring follow-up of recommendations made for children, particularly those at high risk (including responding to missed follow-up appointments);
- Discharge planning when it involves at-risk children being discharged to remote/isolated communities.

**Differential Diagnosis**

Issues with differential diagnosis were identified:

- Approach to ascertainment of severity of illness to inform decision making;
- Assessment and management of infants and neonates, particularly when febrile;
- Detection of congenital heart disease by fetal ultrasound examination;
- Management of Gastrostomy tube in premature babies;
- Approach to prioritization for surgical admission when a child is admitted to hospital with maximal medical management.
**Documentation**

Documentation issues included:
- Importance of regular collection and charting of a complete set of vital signs;
- Policies and procedures for logging/documentation of patient/family telephone calls;
- Review of policies and procedures relating to documentation and retention of patient records;
- Sharing policies and procedures between the healthcare institutions and child and family services involved.

**Transport/Transfer**

Transport/transfer issues included:
- Development of a plan to facilitate transfer if a local transport team is unavailable;
- Challenges associated with transport of seriously ill paediatric patients;
- Paediatric and neonatal transport in remote communities;
- Decision making approach in developing a patient transfer plan.

**PDRC – Medical: Case Example**

This case was reviewed by the PDRC – Medical in 2016 and illustrates the difficulties and challenges that can arise for health care practitioners when caring for paediatric patients.

**File:** 2014-10891 (PDRC-2016-02)

**Date of Death:** October 8, 2014

**Date of Birth:** January 16, 2013

**Age:** 20 months

**Date of Review:** March 2016

**Sources Reviewed:**

1. Coroner’s Investigation Statement (Form 3)
2. Paramedic patient care records
3. Provincial emergency referral service patient report
4. Medical records from:
   - Children’s Hospital
     a. Bridge call report
     b. Bridge call recording
   - Hospital A
   - Hospital B
   - Family physician
5. Report of Post Mortem Examination
Past Medical History:

The decedent was a 20-month-old child with Trisomy 21 who lived with her parents. In the neonatal period, she had surgical intervention for duodenal atresia and aortic infantile coarctation. At six months of age, she had cardiac surgical repair of an atrio-ventricular septal defect (AVSD) at the children’s hospital. She developed chylothorax post-operatively, however this responded to medical management. She was slow to gain weight requiring gastrostomy tube (G-tube) feeding. She had previous bilateral nasolacrimal duct obstruction probed by an Ophthalmologist. Her family doctor supported her general medical care with cardiology care provided by cardiologists at the children’s hospital and another pediatric centre.

Terminal Events:

The child was assessed by her family physician at about 09:00 hours on October 7, 2014 after presenting with a 24 hour history of cough and respiratory tract like illness. She was afebrile with a temperature of 36.7°C. The child’s throat was red (3+) with normal ears and lymph nodes and a clear chest. There was no documentation of vital signs (blood pressure or pulse) or respiratory rate in the medical records relating to this visit. A diagnosis of upper respiratory tract infection was made and she was provided with a prescription of Amoxil.

After return home, her condition deteriorated with development of shortness of breath and respiratory distress. Her parents took her to Hospital A (a 34-bed healthcare facility) at approximately 20:55 hours on October 7, 2014. She was assessed by the emergency room physician at 21:02 hours. Documented vital signs included temperature of 38.9°C, tachypnea with a respiratory rate of 60 breaths/minute, heart rate (HR) 140 and blood pressure 128/78. Her oxygen saturation was 91% in room air. She was noted as agitated and restless. Examination demonstrated presence of intercostal and subcostal indrawing and decreased air entry bilaterally. Few crackles and wheezes were heard on chest auscultation.

Three doses of Ventolin and Atrovent were provided in succession followed by Pulmicort inhalation. A chest X-ray was completed showing bilateral lung infiltrates with the right significant and worse than the left lung representative of fulminant pneumonia. Intravenous access was not able to be obtained precluding collection of blood for culture and other testing. Insertion of an intraosseous infusion needle was attempted, but this access was not achieved as fluid could not be infused. A dose of Clavulin was given via the G-tube followed by intramuscular injection of 1 gram of ceftriaxone. Oxygen was provided via nasal prongs at 4-5 L/minute. Despite these interventions, the child remained mottled and cool. Contact was made with the provincial emergency referral service who facilitated bridge discussion between Hospital A medical staff and the children’s hospital’s Intensive Care Unit.

The Hospital A treatment provider and children’s hospital bridge call staff discussed the case. The call was initiated at 23:16 hours with request made by Hospital A emergency staff for transfer of the child to the children’s hospital. On review of the bridge call recording, the major focus of the communication was lack of appropriate IV access. Concern about the seriousness of child’s condition and acuity was not apparent in post death review of the recording. There was no demonstrable urgency in the discussion despite the seriousness of the child’s clinical condition as demonstrated by the vital signs, physical examination findings and chest X-ray findings.

Staff at the children’s hospital made plans for initial assessment in their emergency department after transfer of the child. The discussion resulted in decision to transfer the child from Hospital A to Hospital B (a 494-bed regional hospital) to expedite assessment and stabilization by a paediatric specialist. The children’s hospital
Transport Team planned to attend Hospital B to facilitate transfer. Air transfer was not available. Paramedic services were contacted by the children's hospital Transport Team to indicate need for an ambulance to facilitate transfer from Hospital B.

Paramedics were accompanied by a general practitioner/anesthetist from Hospital A during land ambulance transfer of the child to Hospital B. The ambulance was requested at 23:49 hours and arrived at Hospital A at about 23:55 hours. Following assessment of the child, the ambulance departed at about 00:09 hours on October 8, 2014. Two set of vital signs were recorded during the transfer to Hospital B. The initial set was noted to have been taken around midnight with pulse rate of 140, respirations 60 breaths/minute, blood pressure 128/78 and oxygen saturation of 93% with supplemental oxygen. The second set of vitals completed at 00:40 hours noted weak pulse of 140/minute, respiration was 60 breaths/minute, and oxygen saturation of 93%. No additional blood pressure measurement was documented during the transfer. The child was described as pale.

Review of incident reports prepared by the paramedics documented that prior to arrival at Hospital B, the child was being bagged by the accompanying physician. There was no evidence of use of a cardiorespiratory monitor. The child was noted to have asystole with absence of vital signs upon arrival at the Hospital B emergency department at 00:50 hours.

CPR was immediately commenced with intraosseous fluid provided. Several doses of epinephrine and atropine were also provided during the unsuccessful resuscitation attempt. The child was pronounced deceased at 01:10 hours on October 8, 2014.

**Post Mortem Examination Findings:**

The child’s weight was 8 kg with height 68 cm; both below the third percentile. The previous areas of surgical intervention, i.e., coarctation, AVSD and duodenal atresia were all free of complication.

There was bilateral acute bronchopneumonia bilaterally, right worse than left.

Polymerase Chain Reaction (PCR) testing from the lung was positive for enterovirus and rhinovirus. Bacterial cultures from the post mortem blood and lung were negative and anti-mortem blood culture was not completed given the vascular access difficulties. There was suggestion of patchy pulmonary arterial medial wall thickening and intimal fibrosis suggestive of pulmonary hypertension. There was a mild left ventricle outflow track stenosis.

- **Cause of Death:** Complications of Acute Bronchopneumonia
- **Contributing Factors:** Trisomy 21, Congenital Heart Disease, Pulmonary hypertension
- **Manner:** Natural

**Comments and Issues Raised:**

This child had a complicated past medical history including Trisomy 21 with surgical repair of duodenal atresia, infantile coarctation, and AVSD, in the first year of life. She had ongoing failure to thrive and was gastrostomy tube dependent for feeding. Children with such medical history are intrinsically at higher risk for infections primarily respiratory, as well as aspiration.

When seen by the family physician the day prior to death, the symptoms were suggestive of a respiratory illness. While there was limited documentation, the child was noted to be afebrile without recording of the respiratory rate or other vital signs. The throat was documented to be red (3+). The working diagnosis was upper respiratory tract infection with Amoxil prescribed. She was likely in early stages of respiratory illness.
Following return home, the child demonstrated deterioration in her respiratory status. She was taken to Hospital A in the evening. Intravascular access could not be obtained as the intraosseous needle was not functioning. Blood testing was not completed. It is unknown if capillary blood testing was available at Hospital A. The child remained at Hospital A for about two hours prior to transfer by the paramedics during which her clinical status remained poor despite medical intervention. This was likely representative of fulminant pneumonia.

Limited documentation was available or completed during the transport to the Hospital B. Blood pressure was not recorded with the other vital signs documented at 00:40 hours during the transfer. It was not clear if there was a cardio-respiratory monitor present in the ambulance and used. A physician accompanied the child during the transfer. The physician was bagging the child as they arrived at Hospital B and the child was without vital signs upon entry into the emergency department. There was no documentation from the physician outlining the events during the transfer. It may have been beneficial to intubate the child prior to transport.

The children’s hospital Transport Team had not departed as the paramedic service was unable to provide an ambulance.

**Recommendations:**

1. Hospital A should consider conducting a lesson learned case review of the assessment and care of the child during the October 7-8, 2014 Emergency Department visit. This review should include:
   a. Physicians and nursing staff from the Department of Emergency Medicine, Anesthesiology and paediatric staff from the routinely assigned paediatric tertiary referral centre.
   b. Suggested areas for focus are:
      - Recognition, assessment and management of seriously ill **high risk** children including, but not limited to:
        - Approach to involvement of tertiary referral centre
        - Anticipating when the trajectory of illness may indicate that it will exceed the capacity of the hospital
        - Clarity of communication of clinical presentation
   c. Consideration of departmental Paediatric Advanced Life Support update education focusing upon:
      1. methods of vascular access and fluid resuscitation
      2. Approach to laboratory testing when intravenous access is not successful
      3. Importance of regular collection and charting of a complete set of vital signs (including blood pressure)
      4. Airway management in a child who has serious respiratory illness

2. The children’s hospital Intensive Care Unit should consider conducting a lesson learned case review of the bridge call with focus on:
   a. Approach to ascertainment of severity of illness to inform decision making
   b. Decision making approach in developing a patient transfer plan.
   c. Communication with Hospital B about the plan upon arrival of the child

3. The Director of the Acute Care Transport Services (ACTS) at the children’s hospital should coordinate with paramedic services to undertake a joint review of the approach to availability of ambulance vehicles when required by the ACTS team.
4. A copy of the case report should be shared with the Provincial Council on Maternal and Child Health as a case example of the challenges associated with transport of seriously ill paediatric patients.

5. The paramedic service for Hospital A should undertake a review of the care and management of the child during the transfer to Hospital B with focus upon:
   a. The approach to patient care when there is a physician present with the patient including:
      i. Paramedic presence with the patient
      ii. Continuous monitoring of a seriously ill child
      iii. Regular completion and documentation of vital signs
      iv. Documentation of clinical care and patient status

Paediatric Death Review Committee – Child Welfare

Child welfare services in Ontario are provided by 38 independent children’s aid societies and eleven Indigenous child wellbeing societies (“Societies”) to deliver child protection services, for a total of 49 societies. All societies receive provincial funding from the Ministry of Children, Community and Social Services (MCCSS), formerly known as the Ministry of Children and Youth Services (MCYS).

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

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

1. The death investigation by the coroner;
2. Children’s aid society / Indigenous child wellbeing society reporting related to these deaths; and
3. PDRC - Child Welfare reviews completed in certain circumstances.

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

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

Prior to 2014, the PDRC – Child Welfare’s annual report focused on an analysis of PDRC case reviews. More can be learned from considering all paediatric deaths with Society involvement, using the information provided by Societies in relation to those deaths. For this reason, this year’s annual report follows the same approach as the 2014, 2015 and 2016 reports.
The PDRC – Child Welfare and the OCC believe that this data is valuable to provide a better understanding of paediatric deaths with Society involvement in Ontario. The OCC continues to receive feedback from many parties about the value of the approach and the utility of the information. It is hoped that by continuing to provide the additional analysis this will assist Societies, policy makers, researchers and the public to identify relevant areas to develop strategies and policies to help prevent further deaths.

Use of data by the PDRC – Child Welfare

There are a number of challenges with the data available for analysis that merit consideration when reading this report, including:

- The data is primarily collected by coroners from across the province. Limits in standardization and non-confirmation of data accuracy may affect the analysis. The OCC is developing a new data capture system that is expected to significantly improve the quality and completeness of the OCC’s data. The development of this system is underway with implementation anticipated in 2019.

- The lack of comparator data from other sources. Data from different sources is collected with varying sets of parameters, depending on the needs of the organization. Some of the data required for effective comparison is unavailable. Other data sets are incomplete, or are measured in ways that do not align with the data that the OCC and the PDRC collect.

- There are varying interpretations of the Joint Directive on Child Death Reporting and Review. We are not proceeding with clarification of the Joint Directive at this time, pending the development of a new model of child death review, to avoid potential duplication of efforts.

In August 2016 a standardized, PDF fillable Child Fatality Case Summary Report was implemented. This has significantly enhanced the consistency in the data collected from Societies. As implementation took place part way through the year, there continues to be some variability in the data collected.

Where an analysis of the five available years of data, 2013 – 2017, was feasible, the results have been included in the report. The data analyzed to-date suggests that there is sufficient variability within the data year-over-year to merit the ongoing examination of the data prior to drawing any conclusions. As time passes and larger data sets are developed the ability to identify trends or draw conclusions from the data will improve. At this time, the significance of some available data is unknown.
PDRC – Child Welfare’s Approach to Statistical Analysis

As in previous years, statistical analysis was completed to determine how “close” observed rates of paediatric deaths are to that expected in the context of one of two standard populations – paediatric coroner’s investigations, or child deaths in Ontario.

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

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

Looking forward: Data-Driven Death Review

Since 2014, the OCC has been working with the Ministry of Children, Community and Social Services (MCCSS) and the Office of the Ontario Child Advocate (OCA) to develop a “best-in-class” model of child and youth death review that will be data-driven, evidence informed and grounded in collaborative partnerships. This will maximize the potential for affecting public health analysis, policy development, and research and prevention strategies in the province of Ontario. All three parties have provided funding to support a Child and Youth Death Review and Analysis Project Team that will be working to implement a new model of child and youth death review over the next two years. To date, the framework for a new model has been developed and pilot projects are expected to be completed by 2020.

Ultimately, the objective of a new model is to improve the health, safety and well-being of Ontario’s children and youth and reduce the child mortality rate in Ontario. We recognize that the factors that influence the circumstances of a person’s death are not isolated to the immediate time surrounding their death; they have intersected with various systems throughout the course of their life, and those systems may have influenced the circumstances of their death. Consequently, to be maximally effective, a new model of child and youth death review and analysis requires integrated data regarding the circumstances of a person’s death and their intersections with systems over their life course. This is key to determining the right areas for targeting further analysis, prevention strategies and areas where research could be of benefit.

To achieve this vision, the new model will leverage data (existing and/or new) to undertake surveillance and identify trends and themes that may point to broader systemic issues – and therefore, target the “right” areas for further analysis to promote and advance death prevention. The OCC is actively working with a number of key governmental partners on designing a data integration pilot that will inform the next steps for Ontario’s model of child and youth death review. Full implementation of the new model is anticipated following the pilot’s evaluation.
2016 and 2017 Paediatric Deaths with Society Involvement Compared to Other Paediatric Deaths in Ontario

In 2016, there were 1,065 deaths of children and youth aged 0 – 18 inclusive in Ontario, of which 405 (38%) of these deaths met the criteria for a coroner’s investigation. Of the paediatric deaths investigated by a coroner in 2016, 115 (28%) of them were reported to the Paediatric Death Review Committee – Child Welfare (PDRC-CW) as a result of Society involvement with the child, youth or family within 12 months prior to the death. In 2017, there were 1048 paediatric deaths of children and youth aged 0 – 18 inclusive, of which 423 (40%) of these deaths met the criteria for a coroner’s investigation. Of the paediatric deaths investigated by a coroner in 2017, 122 (29%) of them were reported to the PDRC-CW as a result of Society involvement with the child, youth or family within 12 months prior to the death. This is consistent with the proportion of deaths from 2015, but slightly higher than the proportion of deaths prior to 2014.

In addition to the 115 deaths reported by a Society in 2016, Societies also reported the deaths of six youth outside of the typical age range of the paediatric group (aged 19 – 21). These six youth were receiving Continued Care and Support for Youth (CCSY) supports from a society at the time of their death. In total, 121 deaths were reported for the year 2016. Similarly in 2017, Societies also reported the deaths of four youth (aged 19-21) that were receiving CCSY supports from a society at the time of their death. In total, 126 deaths reported for the year 2017.

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


By policy, coroners in Ontario investigate all paediatric deaths of children and youth between the ages of 0 to 18 that occur 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. These deaths include natural deaths that under normal circumstances would not likely be investigated by a coroner. In 2016, 30 paediatric deaths fell into this category and in 2017, 20 paediatric deaths fell into this category. These 50 deaths have been excluded from some of the analyses undertaken in this report to allow for the comparison of deaths with Society involvement against the broader population of paediatric coroners’ investigations (which does not include natural deaths free of other concerns). It should also be noted that a Society was involved within 12 months prior to the deaths in all the paediatric deaths that have been excluded from the analyses for both 2016 and 2017.
Therefore, 375 (405 deaths – 30 deaths = 375 deaths) is the number used in some analyses of total paediatric deaths and 85 is the number used in some analyses of total paediatric deaths with Society involvement (115 deaths – 30 natural deaths = 85 deaths) for the year 2016. Similarly, 403 (423 deaths – 20 deaths = 403 deaths) is the number used in some analyses of total paediatric deaths and 102 is the number used in some analyses of total paediatric deaths with Society involvement (122 deaths – 20 natural deaths = 102 deaths) for the year 2017. This is consistent with the approach taken in previous years.

**Coroner’s Cases with Society Involvement Compared with Coroner's Cases without Society Involvement – Gender and Age**

In 2016, a binomial test indicated that the proportion of female decedents between the ages of 0-18 was 41% (n=166) and 41% in 2017 (n=173) which was lower than the expected 50%, p<0.001 for both years. This is consistent with previous years. A binomial test indicated that the proportion of female paediatric decedents investigated by a coroner with Society involvement of 50% in 2016 (n=58) and 56% in 2017 (n=68) was consistent with the expected value of 50%, p=0.068 for 2016 and p=0.078 for 2017.

Charts 13A and 13B demonstrates the proportion of coroner investigations with and without Society involvement within the percentage of all paediatric deaths between the ages of 0-18 that occurred across five age groups in Ontario.

The number of deaths with Society involvement was compared to the number of coroner investigations without such, across age groups to evaluate if the Society involved population was the same as population of paediatric deaths that are the subject of a coroner investigation without Society involvement.

The 2016 and 2017 data, within the context of limitations noted earlier, demonstrated that 15-18 year old decedents were less likely to have Society involvement prior to their death. There was no significant difference in other age groups.

When reviewed as a five-year cohort of data, those under age one and those aged 10 – 14 were proportionately more likely to have Society involvement prior to their death.

The proportion of deaths across age groups was similar from each year, from 2013-2017.

**Chart 13A: Proportion of Deaths across Age Groups in 2016**

Chart 13A compares the proportion of coroner investigations with and without Society involvement within the percentage of all paediatric deaths of children and youth between the ages of 0-18 in Ontario across five age groups in 2016. The data demonstrates that of the coroners’ investigations, 15-18 year old decedents were proportionately less likely to have Society involvement prior to their death. There was no significant difference in other age groups.
Chart 13B: Proportion of Deaths across Age Groups in 2017

Chart 13B compares the proportion of coroner investigations with and without Society involvement within all paediatric deaths between the ages of 0-18 in Ontario across five age groups in 2017. The data demonstrates that of the coroners’ investigations, 15-18 year old decedents were proportionately less likely to have Society involvement prior to their death. There was no significant difference in other age groups.
The regional distribution of Ontario’s paediatric population and paediatric deaths correlate (see Charts 14A and 14B); however, analysis of the available data shows that there is a significant difference across the four regions of Ontario, between the proportion of paediatric deaths in Ontario and the proportion of Coroner's investigations in Ontario with Society Involvement\(^3\).

As in previous years, fewer deaths with Society involvement appear to occur in the Central region when compared to the overall number of child deaths in Ontario and the data continue to suggest that more deaths with Society involvement occur in the North when compared to the overall number of child deaths in Ontario. This has increased from previous years. In 2016, six per cent of paediatric deaths in Ontario occurred in the North overall, with 25% of all Ontario paediatric deaths with Society involvement occurring in that region. Similarly in 2017, seven per cent of paediatric deaths in Ontario occurred in the North overall, with 26% of all Ontario paediatric deaths with Society involvement occurring in that region.

As noted in previous annual reports, there are a number of potential reasons that may be associated with the apparent overrepresentation of child and youth deaths with Society involvement in the North, including but

\(^3\) Chi-square test was performed. Relation between the variables was significant, \(\chi^2 (3, n=1065 \text{ in } 2016) = 93.57, p < 0.0000001\) and \(\chi^2 (3, n=1048 \text{ in } 2017) = 104.25.678, p < 0.0001\).
not limited to: lower health status, challenges to accessing healthcare services and higher mortality rates that increase with remote place of residence\textsuperscript{4}.

In 2016, available data indicated that 68\% of the deaths with Society involvement that occurred in the North region were Indigenous children and youth; in 2017 it was 64\%. This is higher than in 2015 and closer to what was observed in 2014.

While the percentage of all paediatric coroner investigations in 2016 completed in the North – was similar to the percentage of paediatric deaths in that region (6\%), it was less than the percentage of paediatric deaths with Society involvement in that region (25\% in 2016). In 2017, the percentage of all paediatric coroner investigations in the region (7\%) was similar to the percentage of paediatric deaths (6\%) while the percentage of deaths with Society involvement in the North was similarly higher at 26\%. This may suggest that the higher percentage of paediatric deaths with Society involvement in the North relative to other regions may arise from a combination of several factors.

Chart 14A: Proportions of Paediatric Population in Ontario, Paediatric Deaths in Ontario, and Coroner’s Investigations in Ontario with Society Involvement, 2016, by Region

Chart 14A illustrates that the percentage of paediatric deaths occurring in each region of the province is almost the same as the percentage of children and youth across Ontario, by region. More deaths with Society involvement occurred in the North (25\%), when compared to the number of paediatric deaths that occurred in that region as a proportion of total paediatric deaths in Ontario (6\%).

Chart 14B: Proportions of Paediatric Population in Ontario, Paediatric Deaths in Ontario, and Coroner’s Investigations in Ontario with Society Involvement, 2017, by Region

Chart 14B illustrates that the percentage of paediatric deaths occurring in each region of the province is almost the same as the percentage of children and youth across Ontario, by region. More deaths with Society involvement occurred in the North (26%), when compared to the number of paediatric deaths that occurred in that region as a proportion of total paediatric deaths in Ontario (7%).

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

Manner of Death – Coroner’s Cases with Society Involvement Compared with Coroner’s Cases without Society Involvement

The manner of death indicates how children and youth in Ontario die. If the well-being, living environments and circumstances of children and youth across Ontario, aged 0 - 18, with or without Society involvement, were equal, it would be expected that the number of paediatric deaths occurring from a given manner of death would be the same in each category.

It is recognized that vulnerable children and youth have a greater likelihood of receiving services from Societies. The manner of death may provide valuable insight into the impact of services provided, but should not be used as an indicator of the effectiveness of service in isolation of many other indicators because
Societies provide services in the broader context of a number of variables, and are generally not the only service providers engaged with this population of children and youth.

A significant difference was noted between the number of deaths with Society involvement compared to the number of deaths investigated by a coroner without Society involvement, by manner of death\(^5\). Chart 15A illustrates that in 2016, undetermined deaths appear to be more prevalent where a Society was involved with the child, youth or their family prior to the death, while accidents and natural deaths appear to be less prevalent. Suicides were similar or slightly increased. Chart 15B illustrates that in 2017, undetermined deaths and suicides were found to be higher amongst those with Society involvement and accidents and natural deaths were lower amongst those with Society involvement. In both 2016 and 2017, homicides were equivalent amongst those with and without Society involvement. This varies to some extent from findings in previous years.

Interestingly, when viewed as a five year cohort of data, significant differences were present for all manners of death. In previous years, it was found that a greater proportion of children and youth with Society involvement die as a result of homicide or of undetermined manner, while fewer children and youth with Society involvement died as a result of accidents or of natural causes. In 2016 and 2017, the number of suicides with Society involvement was higher than previous years. Caution should be exercised when interpreting these results, however, as the data set remains quite small (n=1918 coroner investigations).

\textbf{Chart 15A: Manner of Death of Coroners Investigations with or without Society Involvement in 2016 (n=375)}

Chart 15A illustrates that in 2016, undetermined deaths appear to be more prevalent where a Society was involved with the child, youth or their family prior to the death at 31%, while accidents and natural deaths appear to have been less prevalent respectively (28%, and 18%). Homicides were found to be equivalent amongst those with and without Society involvement.

\(^5\) A chi-square test was performed. Relation between the variables was significant. In 2016: \(\chi^2 (4, n=375) = 17.109, p < 0.005;\) in 2017: \(\chi^2 (4, n=400) = 13.595, p < 0.009.\)
Chart 15B: Manner of Death of Coroners Investigations with or without Society Involvement in 2017 (n=403)
Chart 15B illustrates that in 2017, undetermined deaths were found to be higher amongst those with Society involvement at 28% and accidents and natural deaths were lower (23% and 22% respectively) amongst those with Society involvement than those without Society involvement. Suicide deaths that had Society involvement were higher (21%) than those without Society involvement. Homicides were found to be somewhat equivalent amongst those with and without Society involvement (4% and 3% respectively). 3% of deaths with Society involvement are currently still under investigation.
What do we know about deaths where the manner of death is undetermined?

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

Chart 16A: Paediatric Deaths Classified as Undetermined – with or without Society Involvement in 2016 (n=73)
Chart 16A illustrates the number of undetermined deaths by age group, with and without Society involvement prior to the death in 2016. Most paediatric deaths that are classified as undetermined occur in children under one year of age, with a smaller proportion occurring in children under five and even fewer in older age groups.

Chart 16B: Paediatric Deaths Classified as Undetermined – with or without Society Involvement in 2017 (n=72)
Chart 16B illustrates the number of undetermined deaths by age group, with and without Society involvement prior to the death in 2017. Most paediatric deaths that are classified as undetermined occur in children under one year of age, with a smaller proportion occurring in children under five and even fewer in older age groups.
Presence of Sleep Associated Circumstance as a Potential Contributing Factor in Undetermined Deaths

In 2016, sleep circumstances were identified in 48% (35) of the 73 paediatric deaths where the manner of death was classified as undetermined; in 2017 this value was lower at 32% (23) of the 72 paediatric deaths where the manner of death is undetermined. 34% (n=12) in 2016 and 39% (n=9) in 2017 of these children or their families received services from a Society within 12 months of their death.

While the data demonstrates a statistically significant difference in the number of deaths of children with and without Society involvement where the manner was undetermined, when considering only those cases where sleep circumstances were identified as potential contributing factors to the death there was no significant difference between Society involved and non-Society involved populations. This is consistent with the findings of previous years. Analysis of a five year cohort does not identify a statistically significant difference. Furthermore, the number of deaths of children with Society involvement where sleep circumstances were identified as a potential contributing factor has been decreasing since this type of data analysis began in 2014.

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6 A Fisher’s exact test was performed. The relation between the variables was not significant, $p = 0.423$.  
7 A Fisher’s exact test was performed. The relation between the variables was not significant, $p = 0.675$.  
50
As noted in previous annual reports, many variables require consideration when interpreting this finding. First and foremost, the small sample size must be considered. In addition, Societies are not the only organizations promoting safe sleep in communities. The independent impact of Society practice on the number of paediatric deaths occurring in unsafe sleep environments is unknown; however, the continued absence of a significant difference between Society involved deaths and those without Society involvement may suggest that the practices of Societies have potentially contributed to the overall prevention of paediatric deaths where sleep environment may be a factor.

### 2016 and 2017 Deaths with Society Involvement – Status of Children and Youth

This is consistent with findings in previous years, 93% (113/121) of the children and youth that died in 2016, where a Society was involved with the child, youth or family within 12 months of the death, were not in the care of a Society at the time of their death. This includes six youth (aged 19-21) that were receiving Continued Care and Support for Youth (CCSY) from a Society (formerly Extended Care and Maintenance), which a youth in care may be eligible to receive when their care and/or custody order expires upon their 18th birthday. Of the 7% (8/121) of children and youth that were in the care of a Society, five were in extended Society care, one was in temporary Society care, one was the subject of a formal customary care agreement and one was subject to a temporary care agreement.

89% (112/126) of children and youth that died in 2017 where a Society was involved with the child, youth or family within 12 months of the death were not in the care of a Society at the time of their death. This included three youth aged 18 and four youth between the ages of 19-21 that were not in care but were receiving CCSY supports. Of the 11% (14/126) of children and youth that were in the care of a Society at the time of their death, six were in extended Society care, one was in interim society care, four were subjects of formal customary care agreements and three were subjects of temporary care agreements.

### What does the available data tell us?

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

- In 2016, 66% and in 2017, 72% of cases where a child or youth, including those receiving CCSY that had been receiving services from a Society were open files at the time of death (see Chart 17A and 17B). This is consistent with previous years.
37% of the cases in 2016 and 46% of cases in 2017 were rated as high or very high risk at the time of death (see Chart 18A and 18B). The Ontario Child Protection Standards released in February 2016 require that when deciding whether more frequent visits are required the worker considers:

- the risk rating on the risk assessment;
- the strengths and needs of the family;
- whether a safety plan is actively being monitored and the child continues to reside in the home; and
- the vulnerability of the child.” (Standard 7, p.83).

Requirements of the Standards would suggest that in these cases, the Society would have been engaging with the family with some frequency prior to the death.

A history of verified abuse and neglect of the child or youth and/or the sibling(s) of the deceased continued to be the most commonly reported vulnerability factor (see Chart 19). 31% of Society reports in 2016 and 47% of Society reports in 2017 regarding the deaths of children and youth indicated that the child or youth had been the subject of verified abuse or neglect, and in 64% of cases reported in 2016 and 63% reported in 2017 indicated that a sibling of the child or youth had been the subject of verified abuse or neglect. In 20% of cases reported in 2016 and 38% of cases reported in 2017, both of these vulnerability factors were present.

Disabilities are the next most commonly reported vulnerability factor (see Chart 19). 37% of the children and youth that died in 2016 and 22% that died in 2017 had physical disabilities, and 22% in 2016 and 18% in 2017 had mental or emotional disabilities. In 9% of cases in 2016 and in 3% of cases in 2017, both of these vulnerability factors were present. Chart 19 provides a comparison of 2015 through 2017 data on vulnerability factors reported by Societies.

Suicide was the manner of death for 17 youth receiving services from a Society (ages 0-18) and one of the youth received CCSY in 2016 (aged 19-21). In 2017, suicide was the manner of death for 21 youth receiving services from a Society and three youth that received CCSY. Of these in 2016, nine were Indigenous youth and in 2017, 17 were Indigenous youth, as compared to three to five per year from 2013 to 2015. There are three known or suspected vulnerability factors related to suicide reported on the Child Fatality Case Summary Report by Societies – child/youth has previously attempted suicide, recently experienced the suicide of a friend or relative, and/or had spoken to someone about suicidal thoughts. For two of the 18 youth in 2016 and 10 of the 24 youth in 2017, there was more than one of these vulnerability factors present. In 2016, six youth had previously attempted suicide, nine had previously spoken to someone about suicidal thoughts and six had recently experienced the suicide of a friend or relative. In 2017, 12 of the youth had previously attempted suicide, 14 had previously spoken to someone about suicidal thoughts and eight had recently experienced the suicide of a friend or relative.
Chart 17A: Case Status at the Time of Death – Society Involved Cases in 2016 (n=121)
Chart 17A shows the case status for Society involved cases of children and youth between the ages 0 – 21 that died in 2016, which includes individuals who were receiving Continued Care and Support for Youth at the time of their death. 67% of cases were open at the time of the death, and 33% of cases were closed at the time of the death but had been open in the 12 months preceding the death.

Chart 17B: Case Status at the Time of Death – Society Involved Cases in 2017 (n=126)
Chart 17B shows the case status for Society involved cases of children and youth between the ages 0 – 21 that died in 2017, which includes individuals who were receiving Continued Care and Support for Youth at the time of their death. 73% of cases were open at the time of death and 27% had been closed within 12 months prior to death.
Chart 18A: Overall Risk Rating at Time of Death/Case Closure – Society Involved Cases in 2016 (n=115)
Chart 18A illustrates the risk rating reported by the Society at the time of death or case closure for Society involved cases in 2016. 10% of the cases were rated very high risk, 27% of cases were rated as high risk, 33% moderately high risk, 35% moderate risk, 11% low risk and 4% were categorized by the reporting Society as “not applicable”.

Chart 18B: Overall Risk Rating at Time of Death/Case Closure – Society Involved Cases in 2017 (n=122)
Chart 18B illustrates the risk rating reported by the Societies at the time of death or case closure for Society involved cases in 2017. 15% of cases were rated as very high risk, 31% high risk, 30% moderate risk, 11% low risk and 13% were categorized by the reporting Society as “not applicable”.

- Very High Risk: 10%
- High Risk: 27%
- Moderately High Risk: 10%
- Not Completed: 4%
- Low Risk: 11%
- Moderate Risk: 35%
- Not Applicable: 3%

54
Chart 19: Known Vulnerability Factors – Society Involved Cases 2015-2017
Chart 19 illustrates the proportion of 2015, 2016 and 2017 cases with Society involvement of children and youth aged 0-18 where the Society reported known vulnerability factors. As in previous years, in both 2016 and 2017, verified abuse and neglect of the child or youth that died and/or their sibling was the most commonly reported vulnerability factor. Disabilities are the second most commonly reported vulnerability factor.
While the information that the Society provides when a child or youth dies is valuable in identifying particular vulnerability factors, there may be other risk factors for children and youth that are not reported through the Joint Directive reporting process. This is because all potential risk factors for children and youth in Ontario are not collected in a standardized way. Furthermore, the factors collected should not be construed as unique to children and youth that have died, or to children and youth that were receiving the services of a Society. It is not known whether the prevalence of identified factors is different in the population of children and youth that have died as compared to the living population of children and youth in Ontario, or receiving services from a Society.

Deaths of Indigenous Children and Youth with Children’s Aid Society Involvement Investigated by the Office of the Chief Coroner in 2016 and 2017

The ability to undertake meaningful analysis of the deaths of Indigenous children and youth served by Societies is affected by limited data available to the OCC. The coroner may not identify children and youth as Indigenous as they rely on the information available in the course of their investigation (information sources include but are not limited to family members, community service providers, the police). This affects the determination of the true number of Indigenous children and youth deaths that were investigated by the OCC in 2016 and 2017. In addition, the number of deaths of Indigenous children and youth where a Society has been involved is small, preventing meaningful statistical analysis. Furthermore, the data available from other sources has limitations (for example, Societies do not report identity or ethnicity).

The available data has been provided; however, given the noted limitations, meaningful inferences cannot be made. The OCC and PDRC – Child Welfare 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.

What does the available data tell us?

- Provincially, of the 46 coroner investigations into deaths of Indigenous children and youth, 27 (59%) received the services of a Society within the 12 months prior to their death in 2016. Of the 55 investigations into the deaths of Indigenous children and youth, 32 (59%) received the services of a Society within 12 months prior to their death in 2017.
- Of the 27 Indigenous children and youth that had received the services of a Society within the 12 months prior to their death in 2016, 20 were involved with Indigenous child wellbeing societies, while the other 7 were involved with non-Indigenous children’s aid societies. Of the 32 Indigenous children and youth that had received the services of a Society in 2017, 28 were involved with Indigenous child wellbeing societies, while the other four were involved with non-Indigenous child wellbeing societies. Indigenous children and youth are served by Indigenous child wellbeing societies when they reside in an area of Ontario in which a designated organization has jurisdiction.
- In 2016 and 2017, there was an increase in the number of deaths of Indigenous children and youth as well as the proportion who were Indigenous in the North Region, where they or their family had
Society involvement within 12 months prior to their death. In 2016, 18 (67%) of the 27 deaths where the Society had been involved with the child, youth or their family within 12 months of the death were identified as Indigenous children and youth and in 2017, 25 (78%) of the 32 deaths were Indigenous children and youth that had Society involvement.

- In 2016, three of the 14 coroner investigations into the deaths of children and youth in the care of a Society or youth in receipt of Continued Care and Support for Youth (CCSY) (formerly Extended Care and Maintenance) involved Indigenous children and youth. One was in Extended Society Care and the other was subject to a formal customary care agreement and one was receiving CCSY. In 2017, six of the 21 coroner investigations into the deaths of children and youth in the care of a Society or youth in receipt of CCSY were identified as Indigenous. Of the six, one was in Temporary Society Care, one was in Extended Society Care and four were subject to a formal customary care agreement. The number of deaths of Indigenous children and youth that had involvement of a Society is too small to allow analysis of the manner of death. Chart 20A and Chart 20B provide available information on the manner of death of the 46 children and youth in 2016 and 55 children and youth in 2017 respectively. The distribution of the manner of death of Indigenous children and youth varies year-over-year and no consistent pattern has been identified.

Chart 20A: Manner of Death among Indigenous Children and Youth in 2016, by Society Involvement (n=46)
Chart 20A provides available information on the manner of death of the 46 Indigenous children and youth that died in 2016, and compares cases with Society involvement to cases without Society involvement. The manners of death in 2016 were: 1 homicide, 16 accidents, 5 undetermined, 9 natural and 15 suicides.
Chart 20B: Manner of Death among Indigenous Children and Youth in 2017, by Society Involvement (n=55)
Chart 20B provides available information on the manner of death of the 55 Indigenous children and youth that died in 2017, and compares cases with Society involvement to cases without Society involvement. The manners of death in 2017 were: 1 homicide, 13 accidents, 10 undetermined, 6 natural and 25 suicides.
Children and Youth in the Care of a Society or Receiving Continued Care and Support for Youth (CCSY) at the Time of Death

Chart 21A: Age Breakdown of Children and Youth in care of Society or receiving CCSY at the time of death in 2016 (n=14)

Chart 21A illustrates that in 2016, eight children and youth (aged 0-18) were in the care of a Society at the time of their death and six youth were receiving CCSY. These 14 children and youth ranged in age from 5 months to 21 years.

Chart 21B: Age Breakdown of Children and Youth in care of Society or receiving CCSY at the time of death in 2017.

21 children and youth were in the care of a Society at the time of their death in 2017 or were receiving CCSY. These children and youth ranged in age from 24 days to 21 years.
Chart 22: Manner of Death of Children and Youth in the care of a Society or receiving CCSY at the time of death in 2015 – 2017

Chart 22 shows the manners of death of children and youth in care or that were in receipt of CCSY in 2015 through to 2017. In 2016 and 2017 there was a decrease in the number of natural deaths than was seen in the previous three years and an increase in the number of suicides. More accidents occurred in 2017 (n=5) than were observed in the previous four years (typically1/year). The number of homicides and undetermined deaths in 2016 and 2017 remained consistent from 2015.

Paediatric Death Review Committee (PDRC) – Child Welfare Reviews of Cases with Society Involvement in 2016

All child deaths are tragic and typically have a number of contributing factors. Occasionally, the actions or inactions by those in a caregiving role (e.g. family members or the child welfare system) may have played a part in the circumstances of the death. The Paediatric Death Review Committee (PDRC) – Child Welfare reviews the circumstances of the death and may make recommendations to the health care sector, child welfare systems and others with a goal to reduce the number of child deaths and/or to improve the services and care provided to children, youth and families. It is anticipated that by examining these cases with a non-blaming approach, we can learn from individual deaths to improve the lives of other children.
Reports Received by the PDRC – Child Welfare in 2016 and 2017

PDRC – Child Welfare cases reported to the Committee are usually not reviewed within the same calendar year in which death occurs. Committee reviews in any given year will include review of deaths occurring in different years (see Chart 24). This results from a number of factors, including: complexity of the investigation, time allotment for completion of other reviews (for example, DU5C), case volume, and other parallel investigations or proceedings, including involvement of the criminal justice system.

In 2016, as required by the Joint Directive, Societies reported the deaths of 121 children and youth to the PDRC – Child Welfare, which included 115 children and youth aged 0-18 years and 6 deaths of youth aged 19-21 years, where the child and/or family had Society involvement within 12 months of the death. In 2017, 126 deaths of children and youth were reported by Societies to the PDRC – Child Welfare, which included 122 children and youth aged 0-18 and four youth aged 19-21. These cases are at various stages of the PDRC review process.

Chart 23A: PDRC Status of 2016 Deaths with Society Involvement
Chart 23A illustrates the status of review for the 121 cases reported to the PDRC – Child Welfare in 2016. 60 of cases did not require a full PDRC review.

<table>
<thead>
<tr>
<th>Status</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed</td>
<td>72 (60%)</td>
</tr>
<tr>
<td>A PDRC Executive Review has taken place, and no full PDRC review is planned. This occurs when the circumstances surrounding the child’s death do not relate in any way to the reasons for services and/or the Society involvement.</td>
<td></td>
</tr>
<tr>
<td>Pending Decision</td>
<td>23 (18%)</td>
</tr>
<tr>
<td>Cases may be pending a decision regarding PDRC review because additional information is required or because there are other pending investigations or criminal justice system involvement</td>
<td></td>
</tr>
<tr>
<td>Full PDRC Review to be Undertaken</td>
<td>13 (10%)</td>
</tr>
<tr>
<td>An internal child death review has been requested from the Society, and the PDRC will undertake a full review of the case.</td>
<td></td>
</tr>
<tr>
<td>Full PDRC Review Completed</td>
<td>13 (10%)</td>
</tr>
<tr>
<td>An internal child death review was requested from the Society, and the PDRC has undertaken a full review of the case.</td>
<td></td>
</tr>
</tbody>
</table>
Chart 23B: PDRC Status of 2017 Deaths with Society Involvement

Chart 23B illustrates the status of review for the 126 cases reported to the PDRC – Child Welfare in 2017. 45% of cases do not require a full PDRC review and 36% of cases are pending a decision.

<table>
<thead>
<tr>
<th>Status</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed</td>
<td>57 (45%)</td>
</tr>
<tr>
<td>A PDRC Executive Review has taken place, and no full PDRC review is planned. This occurs when the circumstances surrounding the child’s death do not relate in any way to the reasons for services and/or the Society involvement.</td>
<td></td>
</tr>
<tr>
<td>Pending Decision</td>
<td>43 (34%)</td>
</tr>
<tr>
<td>Cases may be pending a decision regarding PDRC review because additional information is required or because there are other pending investigations or criminal justice system involvement</td>
<td></td>
</tr>
<tr>
<td>Full PDRC Review to be Undertaken</td>
<td>15 (12%)</td>
</tr>
<tr>
<td>An internal child death review has been requested from the Society, and the PDRC will undertake a full review of the case.</td>
<td></td>
</tr>
<tr>
<td>Full PDRC Review Completed</td>
<td>11 (9%)</td>
</tr>
<tr>
<td>An internal child death review was requested from the Society, and the PDRC has undertaken a full review of the case.</td>
<td></td>
</tr>
</tbody>
</table>

Reports Reviewed by the PDRC – Child Welfare in 2016 and 2017

In 2016, following the process outlined in Chart in Appendix A, the PDRC - Child Welfare reviewed the deaths of 32 children and youth who had involvement with a Society within the 12 month period leading up to their deaths; in 2017 the number of deaths reviewed was 13. Fewer cases were reviewed in 2017 than in previous years due, in part to the work being conducted in preparation for an Expert Panel which reviewed the deaths of 12 young people in residential care; and to the efforts dedicated to the establishment of the Child and Youth Death Review and Analysis (CYDRA) Unit.
Chart 24: Year of death of 2016 and 2017 PDRC Case Reviews

Chart 24 illustrates the year of death for those cases reviewed by the PDRC – Child Welfare in 2016 and 2017. The majority (22) of the 32 cases reviewed in 2016 were of deaths that occurred in 2014 and 2015. The year of death for those cases reviewed in 2016 ranged from 2011 – 2016. For the majority of cases reviewed in 2017, the deaths occurred in 2015 through to 2017 with one case from 2013.

<table>
<thead>
<tr>
<th>Year of Death</th>
<th>PDRC Cases Reviewed in 2016</th>
<th>PDRC Cases Reviewed in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>2013</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2014</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>2015</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>2016</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>2017</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>32</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

Of the 32 cases reviewed by the PDRC in 2016, 19 were males (59%) and 13 were females (41%).

The age of the children and youth at the time of their death ranged from 5 days to 20 years.

Of the 13 cases reviewed by the PDRC in 2017, 5 were males (38%) and 8 were females (62%).

The age of the children and youth at the time of their death ranged from 42 days to 17 years.

Historically, a greater proportion of reviews completed by the PDRC – Child Welfare involve children under one and adolescents. Chart 25A and Chart 25B demonstrate the age categories for the cases reviewed. This information illustrates that in 2016, approximately 1/3 of the PDRC – Child Welfare’s reviews focused upon deaths of children under the age of five, 1/3 on children and youth age 10-14 and 1/3 on those age 15-18 with a small percentage on those age 1-4 and 5-9. There was a different focus for the reviews conducted in 2017 as can be observed in Chart 25B, more than half of the 13 reviews were for deaths of individuals in the 10-14 year age group. This is partly as a result of a decision by the PDRC to stop inclusively reviewing deaths where the manner of death is undetermined and unsafe sleep environment is listed as a factor. The decision to stop the review of these types of deaths was made because on reflection, of the many reviews conducted, substantive new information was not being gained and recommendations were uncommon from these reviews.
Chart 25A: PDRC – Child Welfare Reviews across Age Groups 2016 (n=32)
Chart 25A demonstrates the age categories for the cases reviewed in 2016. This information illustrates that in 2016, 28% of the PDRC – Child Welfare focused upon deaths of children under the age of one, 31% on youth age 10-14, 28% on youth age 15-18, 6% on those age 5-9 and 6% on those age 1-4.

Chart 25B: PDRC – Child Welfare Reviews across Age Groups 2017 (n=13)
Chart 25B demonstrates the age categories for the cases reviewed in 2017. This information illustrates that in 2017, 54% of the cases reviewed at PDRC – Child Welfare focused on the deaths of children and youth age 10-14, 31% on those age 15-18 and 16% on those under the age of five.
Chart 26A: PDRC – Child Welfare Reviews across Manner of Death in 2016 (n=32)
Chart 26A illustrates the manner of death of children and youth whose cases were reviewed by the PDRC – Child Welfare in 2016. The highest number of cases reviewed in 2016 were suicides (11), followed by undetermined (7) and homicide (7), accidents (4) and natural deaths (3).

Chart 26B: PDRC – Child Welfare Reviews across Manner of Death in 2017 (n=13)
Chart 26B illustrates the manner of death of children and youth whose cases were reviewed by the PDRC – Child Welfare in 2017. In the majority of cases for 2017 (8 out of 13 deaths), the manner of death was suicide, followed by two homicides and one accident, natural and undetermined death each.
Of the 32 deaths reviewed by the PDRC – Child Welfare in 2016 where the manner of death was undetermined (n=8), sleep circumstances were identified as a potential contributing factor in two cases (25%).

Of the 32 cases reviewed by the PDRC – Child Welfare in 2016, 41% (13) were open to the Society at the time of death (see Chart 27A). In 2017, 62% (8) of the cases reviewed by the PDRC were open to a Society at the time of death (Chart 27B).

Of the 13 cases open to a Society in 2016, four were in the stages of investigation and assessment, eight were in ongoing protection intervention, one was under protection support, and one was being provided family support/community link/non-protection. Two individuals were in Extended Society Care, one was in Temporary Society Care under a foster care placement and two were in receipt of CCSY. The manners of death for the three children and youth in care in 2016 were undetermined (one), suicide (one) and natural (one).

Of the eight cases open to a Society in 2017, two were subject of a formal customary care agreement, one was under a supervision order, one was receiving protection support and one was living semi-independently under Extended Society Care. The manners of death of the two youth that were in care at the time of their death were both suicide.

Chart 27A: PDRC – Child Welfare Reviewed Cases in 2016 Open vs. Closed (n=32)
Charts 27A illustrates that of the 32 cases reviewed by the PDRC – Child Welfare in 2016, (41%) were open to a Society at the time of death, while 59% of cases were closed to a Society at the time of death.
Chart 27B: PDRC – Child Welfare Reviewed Cases in 2017 Open vs. Closed (n=13)
Charts 27B illustrates that of the 13 cases reviewed by the PDRC – Child Welfare in 2017, eight (62%) were open to a Society at the time of death, while 38% of cases were closed to a Society at the time of death.

PDRC – Child Welfare Case Reviews in 2016 and 2017 – Analysis of Factors Identified through Case Reviews

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

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

In the future, the OCC hopes to align the approach to tracking both sets of information.
Chart 28A illustrates the top ten factors that were most frequently identified in the PDRC – Child Welfare case reviews conducted in 2016. The top ten risk factors identified were substance abuse (66%), mental health (63%), domestic violence (47%), high risk subject child (41%), neglect/inadequate supervision (41%), 3 or more Society referrals (41%), physical abuse (34%), caregivers’ level of cooperation (28%), 3 or more Society openings (28%) and other, which include childhood history with a Society (25%) and criminal activity (25%).

Chart 28B illustrates the top risk factors for the cases reviewed by the PDRC in 2017, which were substance abuse (69%), sexual abuse (62%), mental health (62%), neglect/inadequate supervision (54%), 3 or more Society openings (38%), domestic violence (38%), 3 or more Society referrals (31%), caregivers’ level of cooperation (15%), caregiver capacity concerns (15%) and other factors (24%), which includes criminal activity (8%), childhood history with a Society (8%) and a high risk subject youth that has special needs or is less than one year of age (8%). The top two factors identified in cases reviewed by the PDRC – Child Welfare have been consistent over the last three years, while the top ten factors vary from year to year.
As in previous years, the findings highlight the prevalence of multiple factors in cases reviewed by the PDRC:

- 41% (13 out of 32) of the cases reviewed by the PDRC – Child Welfare in 2016 had five or more of the ten most frequently identified factors present while 38% (5 out of 13) of the cases had these same factors present in 2017.

In 13% (4) of cases, all of the five most frequently identified factors were present (i.e. substance abuse, three or more Society referrals, neglect/inadequate supervision, domestic violence and mental health) in 2016. One case reviewed in 2017 (8%) had all five of the most frequently identified factors present (i.e. substance abuse, neglect/inadequate supervision, physical abuse, sexual abuse and mental health).

- In 9% (3) of cases in 2016, all ten of the most frequently identified factors were present; and in one case (3%), eight of the most frequently identified factors were present.

In 2017, one case (8%) had seven of the most frequently identified factors present.

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

The PDRC – Child Welfare offers recommendations to Societies arising from review of the case materials. 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.

In 2016, the PDRC – Child Welfare reviewed 32 cases and issued a total of 34 recommendations. The recommendations provided by the PDRC were in addition to recommended changes identified by the involved Societies during the internal review process. Of the 32 cases, 13 reviews provided no recommendations.

Recipients of recommendations in 2016 were: 10 individual Societies, the Ministry of Children, Community and Social Services (MCCSS), formerly known as the Ministry of Children and Youth Services (MCYS), a Local Health Integration Network (LHIN), a Police Service and one Regional Supervising Coroner in the Office of the Chief Coroner. Joint recommendations were also made to the Ministry of the Attorney General (MAG), the Ministry of Health and Long-Term Care (MOHLTC) and MCCSS.

In 2017, the PDRC – Child Welfare reviewed fewer cases (13) due in part to the work being conducted in preparation for the Expert Panel which reviewed the deaths of 12 young people in residential care and to the efforts dedicated into the establishment of the Child and Youth Death Review and Analysis (CYDRA) Unit. Of the 13 cases reviewed, a total of 11 recommendations were issued and four provided no recommendations.

Recommendations to MCCSS in 2016 & MCCSS Response

The section below outlines the categories of recommendations most frequently made to Societies by the PDRC – Child Welfare in 2016. Responses from MCCSS, which has responsibility for oversight of all children’s aid societies and Indigenous child wellbeing societies, have been provided for each recommendation grouping by year.

2016 PDRC – Child Welfare Recommendations and Themes to MCCSS

1. The Ministry of Children and Youth Services should consider how best to support a service system to support effective navigation by parents and to coordinated service pathways for high risk youth.

Case planning structures and designated case coordinators are current methods used to assist with coordinating service pathways. The emphasis is often on current challenges, with less focus on future planning and collaboration between service providers.
MCCSS Response

The Ministry of Children, Community and Social Services (MCCSS), formerly known as the Ministry of Children and Youth Services (MCYS), is committed to supporting a coordinated service system for parents to make it easier to navigate and for high risk youth (e.g. youth involved in the child welfare, mental health and youth justice systems).

As part of Ontario’s Mental Health and Addictions Strategy, Ontario is transforming the community-based child and youth mental health system through Moving on Mental Health (MOMH), which was launched in 2012. As part of MOMH, Ontario has established lead agencies in 31 of 33 service areas across the province, which will be responsible for providing a core set of child and youth mental health services in their areas. The aim of MOMH is to transform the experience of children and youth with mental health problems and their families/caregivers so that regardless of where they live in Ontario they will know:

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

Since the launch of MOMH, the ministry and the child and youth mental health sector have been working together to put in place the foundations to support a high-quality responsive system that meets the needs of children and youth. Creating pathways to care is one of five pillars of MOMH. Through local planning work, lead agencies are working to identify and build clear pathways across the health, education and broader child and youth serving sectors.

To further strengthen service collaboration, the ministry is also working with the Ministry of Health and Long-Term Care (MOHLTC), and the Ministry of Education (EDU) to identify opportunities to build on the local work done to date, and support enhanced connections and planning for children and youth experiencing mental health problems. The ministry is committed to strengthening inter-ministerial collaboration and continuing to improve the mental health and addictions service system across sectors and across the lifespan of children and youth.

In addition to MOMH, the ministry in collaboration with EDU, and MOHLTC, launched the Special Needs Strategy in February 2014 to help connect children and youth with special needs to the services they need as early as possible and to improve the service experience of families in three key areas:

1. **Identifying children earlier and getting them the right help sooner**
   
   Trained providers will have a new developmental screen for children in the preschool years. They will screen for potential risks to the child’s development as early as possible.

2. **Coordinated Service Planning**

   New service planning coordinators for children and youth with multiple or complex special needs will collaborate across sectors to connect families to the right services and supports and develop one, cross-sectorial coordinated service plan.

3. **Making supports and service delivery seamless**

   The goal of coordinated service planning is to improve service experiences and outcomes for children and youth with multiple and/or complex special needs and their families through the
support of a Service Planning Coordinator who will connect them to the multiple, cross-sectorial services they need as early as possible, and monitor their needs and progress through a coordinated service plan.

2. The Ministry meet with the Society, with the participation of the relevant Chief and Council, in order to facilitate reflective learning on cases.

There were ongoing concerns present within the family in a particular case that placed the children at risk of harm. There is opportunity to review service standards and service provision to ensure the safety and well-being of children and youth served by the Society.

**MCCSS Response**

The Ministry and Society have engaged in discussions with respect to relationship building and community involvement in case planning for First Nations children and youth receiving child welfare services.

A meeting with a Society Senior Management was held on June 19, 2018 to discuss the next steps for the PDRC recommendation.

The meeting with the community will be set-up by the Society. The meeting will discuss the process of case consultations and partnership, with a focus on where improvements can be made to ensure better outcomes for children and youth.

**To the Ministry of the Attorney General (MAG), Ministry of Community Safety and Correctional Services (MCSCS) and Ministry of Children, Community and Social Services (MCCSS):**

1. The Ministries of Health and Long Term Care, the Attorney General and Children, Community and Social Services work collaboratively to:

   a. Clarify the legislation as it relates to definition of roles, responsibilities and procedures for professionals related to capacity and consent in the treatment of paediatric patients.

There are different legislative frameworks that apply in the medical treatment of children, including the Health Care Consent Act and the Child and Family Services Act. There appears to be a lack of clarity regarding the circumstances for which each specific legislation applies, and clearly defined roles, responsibilities and procedures for various professionals. This lack of clarity has the potential to result in challenges when approaching case management decisions and increases the vulnerability of children and youth receiving medical treatment.

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8 At the time the response was submitted to the OCC, the new Child, Youth and Family Services Act, 2018 had not been proclaimed. Throughout the rest of the report, the legislation will be referred to as the previous Child and Family Services Act, 1990 (CFSA).
b. Consider the development of standardized processes and procedures for health care professionals when intersecting with child welfare professionals related to capacity and consent in the treatment of paediatric patients with a view to reducing inconsistencies in practices across Ontario.

The ministries may wish to engage the Chiefs of Paediatrics, the Ontario Association of Children’s Aid Societies, the Association of Native Child and Family Services Agencies of Ontario, Aboriginal Elders and/or the Office of the Provincial Advocate for Children and Youth to develop best practice guideline(s) for health care providers and children’s aid societies to follow in similar circumstances. This may include guidelines regarding the importance of documentation regarding decision making as it relates to consent and capacity in paediatric patients and their families.

Case examples to help elucidate processes in various circumstances may be of benefit to medical and child welfare service providers in Ontario.

c. Engage with aboriginal stakeholders, in collaboration with the Ministry of Aboriginal Affairs, to define best practices for professionals related to capacity and consent in the treatment of paediatric aboriginal patients.

Best practice guidelines that address the unique considerations specific to aboriginal children and families would encourage and support decision-making in circumstances where aboriginal children and/or their parents choose to integrate traditional healing practices with physician-recommended treatments or where aboriginal children and/or their parents choose to stop physician-recommended treatments and medical opinion suggests that the consequences for the child could be serious.

**MOHLTC and MCCSS Response**

1a. MOHLTC and MCCSS will not pursue legislative amendments to the Health Care Consent Act, 1996 (HCCA) or the Child and Family Services Act, 1990 (CFSA) at this time. The ministries have determined that there would be broader policy implications and unintended consequences associated with amendments to HCCA.

In reviewing the report of the PDRC, the ministries determined that the issues identified in the report indicate that further clarification in understanding existing regulations can be achieved by enhancing education and awareness among health and child welfare sectors. MOHLTC has begun to take this action by requesting that the health regulatory colleges share information with their members on the CFSA's requirement that suspicions that a child may be in need of protection be promptly reported to a Children’s Aid Society.
1b. MCCSS and MOHLTC will issue a joint memo to all hospital CEOs and Society senior management to request that hospitals examine existing policies and procedures related to capacity and consent and duty to report laws in Ontario and work with their local Society to make any necessary improvements. The memo will highlight best practices and provide guidance on what successful policies should contain, such as the requirements of the HCCA and a child's role in making health care decisions, including complex treatment decisions. Furthermore, it will list resources that are available on consent and capacity.

1c. Engagement with Indigenous and system partners has identified a lack of informed knowledge and best practices on cultural safety on the part of health care providers as a key factor affecting care and decision-making. MOHLTC, in collaboration with MIRR, continues to engage with Indigenous stakeholders to define and integrate best practices for health professionals related to capacity and consent in the treatment of paediatric Indigenous patients that will complement, support and reinforce the responses to recommendations 1a and 1b. For example, the ministry has invested in Indigenous Cultural Safety training for health professionals and health service providers that is designed to increase knowledge, enhance self-awareness and build on existing skills to move towards a culturally safe health care system for Ontario's Indigenous peoples and communities.

As part of the joint memo with MCCSS to all hospital CEOs and Society senior management (response to Recommendation 1b), MOHLTC will request that hospitals examine existing Indigenous education, policies and procedures related to culturally appropriate and safe care for Indigenous patients accessing treatment. The ministry will also continue to invest in initiatives that support cultural safety training, relationship building and harmonizing traditional Indigenous and Western health practices.

**Implementation Status of 2015 and 2016 PDRC – Child Welfare Recommendations to Societies**

MCCSS monitors the implementation status of the PDRC – Child Welfare recommendations and the actions taken by Societies to respond to specific recommendations. MCCSS reports that Societies have implemented or were in the process of implementing 88% of the PDRC – Child Welfare’s recommendations directed to them in 5. Societies were unable to evaluate 8% of the recommendations and the remaining % of recommendations had the content or intent of the recommendation already in place. In 2016, MCCSS reported that 100% of the PDRC – Child Welfare’s recommendations directed to Societies had the content or intent of the recommendation already in place.

**PDRC – Child Welfare Recommendations to Other Organizations in 2016**

The PDRC – Child Welfare also made recommendations to other organizations, which included a Local Health Integration Network and a Police Service. Themes of these recommendations include using a PDRC case as a learning opportunity with a view to enhance service delivery and reviewing existing processes to ensure consistency with protocols. The committee also identified an opportunity for the Regional Supervising Coroner to work with a Hospital Chief of Pediatrics and Emergency Department for learning opportunities to potentially inform future service delivery.
Committee Membership

Paediatric Death Review Committee (PDRC)

**Dr. Dirk Huyer** – Chair  
Chief Coroner for Ontario

**Ms. Kathy Kerr**  
Coordinator (Medical)  
Executive Lead, Committee Management  
Office of the Chief Coroner

**Ms. Jessica Diamond**  
Coordinator (Child Welfare)  
Executive Lead, Child Welfare  
Office of the Chief Coroner

**Dr. Desmond Bohn**  
Provincial Medical Director-CritiCall Ontario

**Mr. Brad Bain**  
**Ms. Zel Fellegi**  
**Ms. Donna Zan**  
**Ms. Corrie Tuyl**  
Child Welfare Consultants

**Dr. Alan Hudak**  
Paediatrician, Orillia

**Ms. Mary Ballantyne**  
Chief Executive Officer  
Ontario Association of Children’s Aid Societies

**Ms. Theresa Stevens**  
Executive Director, Anishinaabe Abinoojii Family Services  
Association of Native Child and Family Service Agencies of Ontario
Dr. Ram Singh
Director, Paediatric Critical Care Unit
Children’s Hospital
London Health Sciences Centre

Det. Avi Fagu
Det. Jakub Ostaszewski
Coroners Police Investigators

Dr. David Chiasson
Pathologist, Hospital for Sick Children, Toronto

Det. Sgt. Jim Kilby
York Regional Police

Dr. John Watts
Professor Emeritus, Department of Paediatrics
McMaster University Medical Centre, Hamilton

Det. Susan Gomes
Homicide Squad, Toronto Police Service

Dr. Ian Wilson
Paediatrician, Kitchener

Dr. Burke Baird
Paediatrician, McMaster University Medical Centre

Det. Sgt. Larry Wilson
Homicide Bureau, York Regional Police

Dr. Alejandro Floh
Critical Care, Hospital for Sick Children, Toronto
Det. Sgt. Lynne Buehler
Investigative Services
Peterborough Lakefield Police

Ms. Yasmin Nowsherwanji
Administrative Coordinator,
Office of the Chief Coroner

Deaths Under Five Committee (DU5C)

Dr. Dirk Huyer – Chair
Chief Coroner for Ontario

Ms. Kathy Kerr
Executive Lead, Committee Management
Office of the Chief Coroner

Ms. Jessica Diamond
Executive Lead, Child Welfare
Office of the Chief Coroner

Det. Susan Gomes
Homicide Squad, Toronto Police Service

Dr. David Chiasson
Forensic Pathologist
Hospital for Sick Children, Toronto

Dr. Charis Kepron
Forensic Pathologist
Eastern Ontario Regional Forensic Pathology Unit, Ottawa
Det. Sgt. J. J. Allan  
Homicide Unit, Durham Regional Police

Det. Sgt Mitch Martin  
Homicide Unit, Durham Regional Police

Dr. Mike Shkrum  
Head, Regional Forensic Pathology Unit, Southwestern Ontario  
London, Ontario

Dr. Michelle Shouldice  
Paediatrician  
Suspected Child Abuse & Neglect Program  
Hospital for Sick Children, Toronto

Det. Insp. Paul McCrickard  
Ontario Provincial Police  
Criminal Investigations Bureau

Dr. Jayantha Herath  
Forensic Pathologist  
Provincial Forensic Pathology Unit, Toronto

Det. Marc-Andre Guy  
Ottawa Police Service

Ms. Yasmin Nowsherwanji  
Administrative Coordinator  
Office of the Chief Coroner

Staff Sgt. Todd LaMarre  
Windsor Police Service
Det. Cst. Brian Welsh
Guelph Police Services

Det. Peter Thom
Hamilton Police Service

Staff Sgt. Vicki MacDonald
Waterloo Police Service

Det. Sgt. Peter Trimble
Toronto Police Service – Homicide

Det. Sgt. John Braybrook
York Regional Police

Staff Sgt. Rhonda Corsi
York Regional Police

Ms. Brenda Marsillo
Product Safety Officer
Consumer Product Safety, Health Canada

Ms. Mary Ellen Hurman
Crown Attorney
Ministry of the Attorney General, Toronto
Appendix A – Joint Directive on Child Death Reporting and Review

Chart 29 shows the process and timelines arising from the 2006 Joint Directive between the OCC and MCYS for Child Death Reporting and Review.

Chart 29: Joint Directive Flow Chart – Office of the Chief Coroner and Ontario Children’s Aid Societies
Society Internal Child Death Reviews

When is an internal child death review requested?

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

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

Why is an internal child death review requested?

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

Who completes the Society internal child death review?

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

Levels of PDRC – Child Welfare Reviews

There are three levels of PDRC – Child Welfare review:

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

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

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

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

**Society Response to PDRC – Child Welfare and Internal Review Recommendations**

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

Findings and recommendations from these reviews have been utilized to change practices, develop training, policy and procedures and to initiate new approaches and programs.
Substance Abuse: Society documented that at least one of the caregivers suffered from substance abuse issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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