youth death review

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Abstract
The mandate of a formal child death review (CDR) system is to advance understanding of how and why children die, to improve child health and safety, and to prevent deaths and injuries in the future. Areas in which CDR has provided valuable information and/or intervention include sudden death in infancy, unintentional injuries (the leading cause of death in Canadian children and youth one to 19 years of age), suicide in youth, and deaths due to homicide or child maltreatment. When collected systematically using common definitions, information regarding deaths in children and youth can help with understanding the scope of problems. Information about the context of a death can inform potential prevention or intervention activities. CDR can improve medical and mental health best practices, child welfare policies and procedures, and legislation and education relevant to public health and safety. In the United States, the United Kingdom, Australia and New Zealand, CDR processes are mandated by legislation. In Canada, death review teams have diverse structures and functions, and the CDR system is less well developed. The present statement addresses the need for formal, organized child and youth death review in Canada to help strengthen and systemize injury and death prevention efforts.

KEY WORDS: Canada; Child death review; Injury prevention; Youth

There are currently no national standards in Canada for child death investigations, data collection around the circumstances of child deaths or death review processes. Major causes of death in childhood and adolescence in Canada include sudden death in infancy (sudden infant death syndrome [SIDS] or death due to an undetermined cause), congenital and medical disorders, unintentional injuries, suicide and homicide. Death and serious injury review teams have evolved in response to the need to better understand factors contributing to child deaths, with a focus on preventing similar losses in the future through health promotion, environmental change and public policies that increase safety and child protection. Unintentional injuries are the leading cause of death in Canadian children and youth one to 19 years of age. In 2004, injuries to Canadians cost $19.8 billion in health care expenditures and lost productivity, of which $16.0 billion resulted from unintentional causes. Of this, almost $3 billion could be accounted for by falls and transport-related injuries to children and youth from birth to 19 years of age. In 2005 alone, child and youth injuries from all causes cost 720 lives in Canada. While the rates of both death and hospitalization due to unintentional injury have declined in recent years, ample opportunity remains to reduce rates further by understanding the factors that contribute to these events and implementing prevention efforts.

In Canada, government entities such as the Public Health Agency of Canada and Health Canada’s Consumer Product Safety Branch, along with health and safety organizations, such as the Canadian Paediatric Society and Parachute, have contributed both as leaders and advocates in injury prevention initiatives, surveillance and research. The present statement addresses the need for a formal, standardized child death review (CDR) process in Canada, with the use of this acronym intended to include both children and youth. Improved CDR would define and systemize mechanisms of injury and maltreatment, and strengthen death prevention efforts. Ultimately, better procedures would facilitate policy change and improve child and youth health and welfare.
What is CDR?
The process of child and youth death review emerged in the United States in the late 1970s in the form of local review teams. In the early 1990s, following a Missouri study investigating child abuse deaths, national- and state-level models emerged as efforts to improve service delivery and child abuse reporting. By the end of the decade, most states were engaged in some form of CDR. In recent years, the CDR process has become increasingly standardized among states and a paradigm shift – from an investigative focus to one that includes and highlights prevention efforts – has occurred. There are ongoing efforts to improve data collection through a national case-reporting system and to augment research informing these efforts. In Canada, death investigation processes are structured under the authority of provincial/territorial law and the national criminal code. Death review was developed to meet requirements of quality assurance and accountability, in some cases resulting from inquiry into adverse outcomes and concerns around missed maltreatment-related deaths.

The purpose of CDR is “to conduct a comprehensive, multidisciplinary review of child deaths, to better understand how and why children die”. A CDR forum avoids fault-finding with service providers or the care provided. CDR is an opportunity for stakeholders from multiple disciplines and involved agencies to engage in meaningful dialogue, share information and learn from one another with the goal of using “… the findings to take action that can prevent other deaths and improve the health and safety of children”.

What are the objectives of CDR?
The aims and objectives of CDR have a wide scope, and can be adapted by the agencies involved to provide effective approaches and to meet any existing jurisdictional legal requirements. Examples of core objectives are highlighted in Box 1. Core team members may include a medical examiner or coroner, law enforcement representatives, child welfare agency workers, local public health, the crown attorney, and a pediatrician, family physician or emergency room physician and/or other health care providers, preferably with some expertise in child maltreatment. Depending on the individual case, other appropriate participants may include emergency medical services personnel, school representatives, child care providers, clergy, or family violence experts, among others.

Once this team is assembled, the typical case review process includes the relevant history, discussion of the death or injury investigation, and an examination of services and systems involved before death. Consideration is then given to: 1) identifying potentially modifiable risk factors, both specific to the case and systemic; and 2) reviewing agency policies and practices to prevent the occurrence of similar events in future.

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<th>Box 1: Objectives of child and youth death review</th>
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<td>1. The accurate identification and uniform, consistent reporting of the cause and manner of every child or youth death.</td>
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<td>2. Improved communication and linkages among local and provincial/territorial agencies, with better coordination of efforts.</td>
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<td>3. Improved agency responses when investigating child or youth deaths.</td>
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<td>4. Improved agency responses in protecting siblings and others in homes where a child or youth has died.</td>
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<td>5. Improved criminal investigation and prosecution of child or youth homicides.</td>
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<td>6. Better delivery of services to children and youth, families, care providers and community members.</td>
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<td>7. To identify specific barriers and systemic issues involved in the death of children and youth.</td>
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<td>8. To identify significant risk factors and trends in child or youth deaths.</td>
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<td>9. To identify and advocate for needed changes in legislation, policy and practices, and expand preventive health and safety efforts.</td>
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<td>10. Increase public awareness of and advocacy for societal issues affecting the health and safety of children and youth.</td>
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Adapted from reference [9]
**Potential outcomes of CDR**

Systematic CDR may lead to better trend recognition in cases of fatality, such as the presence of modifiable risk factors or recurrent systemic issues in communities or families. The CDR team can also formulate recommendations to report on and modify risk factors at local, provincial/territorial or national levels. These reports are anonymous and do not identify specific children or youth but, rather, highlight common themes for preventing similar deaths.\[10][11]

As a result of CDR, important lessons are being learned in the areas of: injury, maltreatment and death prevention; the identification of modifiable risk factors pertaining to particular individuals, families and environments; and factors relating to service needs and provision.\[12] Examples of positive policy changes, prevention efforts and public health initiatives as the result of CDR in the United States are listed in Box 2.\[13] In Canada, published recommendations from provincial death review include safe sleep advocacy, youth suicide prevention initiatives and the safer operation of motor vehicles.\[10][11] These teams have recommended changes to training for child welfare and public health providers and for improving communication between death investigators and the child protection system.\[10][11]

The state of CDR in Canada: A call for action

The death of a child is a tragic event and arguably even more so when it could have been prevented. In the United States, the United Kingdom, Australia and New Zealand, CDR processes are mandated by legislation. In Canada, the CDR system is less well developed.\[14] In the United States, review components, such as the designated lead agency responsible, established protocols and requirements regarding process, coordination and reporting, can vary among states.\[15] In a 2010 policy statement, the American Academy of Pediatrics’ Committee on Child Abuse and Neglect, Committee on Injury, Violence and Poison Prevention, and Council on Community Pediatrics highlighted the importance of child fatality review in preventing childhood deaths.\[16] They argued for financial and legislative support for systematic data collection, enhanced training and dissemination of information resulting from CDR. They also described ways for paediatricians to become involved in establishing and participating in these processes.\[15]

Currently, only a few Canadian provinces or territories have formal CDR processes. Ontario and British Columbia programs are funded under the provincial chief coroners, who issue a widely available annual report and provide recommendations (if identified) at an individual case level. In Manitoba, a number of review processes are in place with differing mandates and oversight, including the Children’s Inquest Review Committee and the Child Health Standards Committee under the provincial College of Physicians and Surgeons. In Alberta, all deaths of individuals younger than 18 years of age are reviewed by a multidisciplinary committee chaired by the chief medical examiner. In other provinces and territories, internal CDRs may occur on an ad hoc basis (eg, for children who die in hospital). For children in care or receiving services from a child welfare agency, the review and reporting of death and serious injury are required across all jurisdictions.\[17]
Box 2: Child safety and injury prevention actions resulting from child and youth death review

| 1. Creation of Cribs for Kids programs to obtain cribs for families in need. |
| 2. Public education on safe sleep and safe sleep media campaigns. |
| 3. Stronger policies and training for health care providers on reporting child abuse and neglect. |
| 4. Suicide prevention incorporated into teacher in-service education |
| 5. Tougher penalties for drunk drivers. |
| 6. Support for smoke detector installation programs. |
| 7. Prescription drug round-ups to facilitate safer disposal of medications. |
| 8. Improved death scene investigation protocols and training for investigators. |
| 9. Folic acid awareness programs. |
| 10. Water safety initiatives such as pool fencing ordinances, swimming lessons for children from low-income families and providing lifeguards at public beaches. |

Adapted from reference [13]

Action is needed
The importance of the CDR process has been well established in the United States and other countries, along with significant positive outcomes such as effective injury prevention campaigns and legislative changes to safeguard the lives of children and youth (targeting safe sleep practices, suicide prevention, youth drivers, all-terrain vehicle operators, and changes in child protection training and information-sharing protocols).[10][12] However, discrepancies among programs and a lack of national leadership have been highlighted as barriers to more effective and coordinated national prevention strategies.[18]

Recommendations
To provide evidence-informed injury prevention programs and policies, the Canadian Paediatric Society recommends that a comprehensive, structured and effective CDR program be initiated for every region in Canada, with systematic reporting and analysis of all child and youth deaths and the ability to evaluate the impact of case-specific recommendations. CDR should be mandated under provincial/territorial or regional legislation, and have:

- Broad representation. The CDR team should include the regional chief medical examiner or coroner and representatives from law enforcement, child protection services, local public health, the crown attorney, as well as a paediatrician, family physician and/or other health care provider. As required, on a case-by-case basis, other participants may include agencies with relevant involvement or knowledge (eg, emergency medical services, school officials, child care providers, clergy or domestic violence representatives).

- Structured processes. Required data collection elements should include a reporting protocol to identify emerging trends in and causes of serious injury or mortality, and pathways for implementing effective policies and programs to address prevention efforts.

- Linkable databases. For meaningful data collection, consolidation and dissemination, more systematic data collection, including surveillance and data-sharing, would generate and support national programs and policies, as needed.

- An evaluative mechanism would determine the effectiveness of CDR follow-up and recommendations.

- Designated financial support from all levels of government.

The time has come for individuals involved in the care of children and youth to advocate for legislated, structured CDR across Canada. Ideally, review processes
should be developed with provincial/territorial chief coroners or medical examiners. This collaborative approach would help to ensure consistent, systematic case review and reporting, and to better inform injury, maltreatment and death prevention efforts nationwide.

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References


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