

TABLE OF CONTENTS

Part Executive Summary.....4

Part Introduction.....5

 The Problem.....5

EXECUTIVE SUMMARY

At present, there are no comprehensive Canadian statistics on the incidence of child abuse and neglect deaths. In conducting research into child abuse and neglect fatalities, it became obvious that definition is both a critical factor for success and a current barrier to accurate counting of child maltreatment deaths in Canada. Efforts in the USA have yielded similar results that are 50 states counting fatalities in ways that are sufficiently different to make national counting difficult task.

Canada's twelve Chief Coroners and Chief Medical Examiners meet yearly to consider these and other issues with respect to their own work. The twelve Directors of Child Welfare in Canada also have regular meetings to discuss issues of common interest. The provincial Child Advocates in Canada also have regular contact around issues of policy and practice. These systems, plus the existence of national organizations of Chiefs of Police, offers opportunity for Canadians may be able to work together to arrive at an accurate count of the number of Canadian children who die each year from acts of commission or omission by those adults responsible for their well-being. This is a very serious issue.

INTRODUCTION

The Problem

The death of a child from a preventable cause is a tragic event. When that cause is child abuse or neglect, the public expects that efforts will be made to reduce such deaths. Governments and law enforcement agencies often receive much of the pressure to reduce child maltreatment fatalities. However, preventive efforts

0 74743040 420
709 242942740 2
843042304243770
748929988420 9

CHIRPP provides reports on a variety of injuries, including playground equipment, baby walkers, cribs, cinder blocks, bassinets, falls from porches, open windows, car doors, strollers and cribs. Although this system was designed to protect children from unnecessary debilitating injuries and premature death, it is a major shortcoming related to identifying abuse and neglect related injuries. During hospital admission, the accompanying adult

The Annual Fifty State Survey

The National Committee for Prevention of Child Abuse (NCPCA, 1992) attempts to collect detailed information from the fifty states and the District of Columbia on the number and characteristics of child abuse reports, the number of child abuse fatalities and cases in the funding and scope of child welfare services. Since 1966, NCPCA has published an annual report providing an analysis of their results including an estimate of the number of child abuse reports and child abuse fatalities

mentioned below in the discussion of death collection systems, some provinces are in the process of developing systems or have just implemented processes for retrieving information on this type of death. For example, for the chief coroner's offices in Ontario can retrieve information on all cases of child death for the 'undetermined'. The new system for it is being developed will contain sub-categories for 'undetermined' to distinguish between possible child abuse and neglect deaths versus for other reasons of death. The chief coroner's offices in British Columbia have a code for

of possible or probable homicides.

technical specialists) could “query the database to produce reports and analysis. Not surprisingly, Coroners and Chief Medical Examiners experienced few of these barriers as their systems were designed to track and analyze information related to deaths, including child deaths. The British Columbia Children’s Commission is currently “buildin

With the exception of one province, information was obtained from each province or territory through survey or semi-structured interviews (or both). Differences in emphasis between descriptions of jurisdictions do not suggest that one region is “better processed” than another. It reflects which systems responded to requests for interviews as well as the detail that was provided during those interviews. A further clarification

autopsy and Sudden Infant Death protocols. Sudden or unexpected deaths of children are investigated; serial Sudden Infant Death Syndrome deaths, all homicides and suicides in addition to some natural deaths that have not been issued death certificates by physicians. A unique investigative feature is the creation of psychological profiles of each child where

investigation. The Children's Commissioner and the Deputy Commissioner present draft to the Commission's consultative committee which meets five times a year and reviews 20 to 40 cases at each meeting. At these meetings, consultative committee members do not pose

If the deceased was under the age of 21 years, the Coroner's office notifies the Department of Social Services (DSS). The DSS determines if there has been child welfare involvement. In investigation of the deaths of young children, the Chief Coroner orders full

in the recommendations and to the families of
the child or children concerned. Since the
families, the departments and agencies have

Child and Family Services have been addressed

needs to develop Terms of Reference and consider additional members from the mental health and public health systems.

Manitoba's Child Advocate's role

mandated role in child deaths unless family

member or the media requests the Advocate's

The Ontario Association of Children's Aid Societies is a membership organization representing 52 of 55 Children's Aid Societies

QUEBEC

Deaths of Children

The current Coroner system in Quebec was implemented in 2006 following the recommendations of the Commission of Inquiry into the deaths of children in Quebec.

that made the committee uneasy. Further investment was requested and eventually, one of the parents admitted to supplying the baby.

The two committees are set up on similar models; both are chaired by pediatricians with expertise in child maltreatment, both practice at major Children's Hospitals; the St. Justin Children's Hospital in Montreal and the University Hospital in Quebec. The Deputy Coroner sits on the Quebec City committee and full time coroner sits on the one in Montreal. Each committee's member from the Surêté de Quebec, the provincial police force, and the one in Montreal's member from the SPCUM, the urban police force in that city. Both committees have members from the child welfare service; the one in Montreal also represents from Bts w, the En lis GXIVC ildrN.34UVo N P46V s re N3B4 V ency. N3B4 VT e N3 Minister of Justice that the committees be made permanent part of the coroner service in Quebec. This recommendation has been accepted by the government of Quebec.

The Coroner's office is also made other changes in recent years to improve the



9707
7 20
0
7 8
07

QUÉBEC

Child Welfare

Coroner

Child Death Reviews

New Brunswick's Minister of Health and Community Services instituted a child death review committee in 1991. A retired judge of the Provincial Court serves as Chairperson and members include a police officer, pediatrician, University social work professor and representative from the office of the Chief Coroner. The Child Death Review Committee

YUKON TERRITORY

Deaths of Children

In the Yukon Territory, the Chief Coroner

reportable. The police and hospital (or Nursing Stations) notify the Chief Coroner of deaths.

chronically unsupervised child is struck by a car while crossing a busy street alone. For coding purposes, the manner and use of death are the same but the circumstances are quite different.

During interviews with survey respondents, the researchers asked about "wisest list for nation" and the base of information based on reviews of child deaths. Evaluation of the impact of specific risk factors, including substance abuse, domestic violence and previous child abuse would make it possible to compile a profile of families at risk for fatal or severe abuse or neglect. (Durfee et al, 1992) There would also be the benefits derived from identifying trends, comparing data across the country by geography; such data base could be more than "data receptacle". Common definitions of terms and common data base were frequent suggestions. The issue of common definitions is a story in the child welfare literature as a barrier to data collection and to meaningful comparison

END NOTE C-

1 A total of 90 surveys were mailed out; some were duplicated within provinces and systems for a total of 70.

APPEND X A

Project Advisory Committee

The Advisory Committee to the Child Mortality Analysis Project is a multi-disciplinary committee of professionals involved in child death reviews. The membership includes (in alphabetical order):

Mr. Larry Campbell, Chief Coroner, Province of British Columbia

Dr. Gréme Dowling, Medical Director, Province of

Mitchell, L. (1977). Child Abuse and Neglect Fatalities: A Review of the Problem and Strategies for Reform. Chicago, IL: The National Committee

