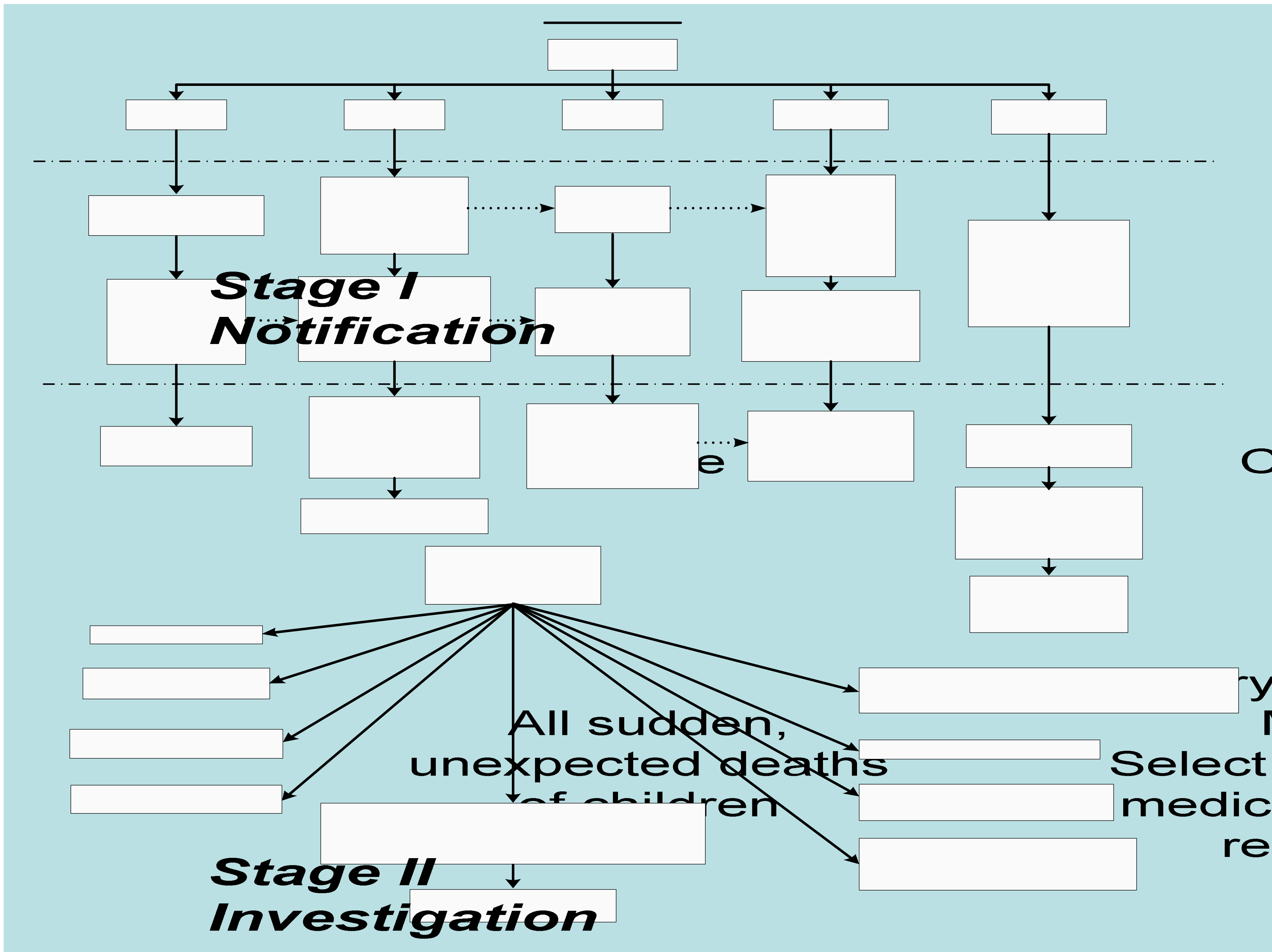
World Conference on Prevention of Family Violence 2005

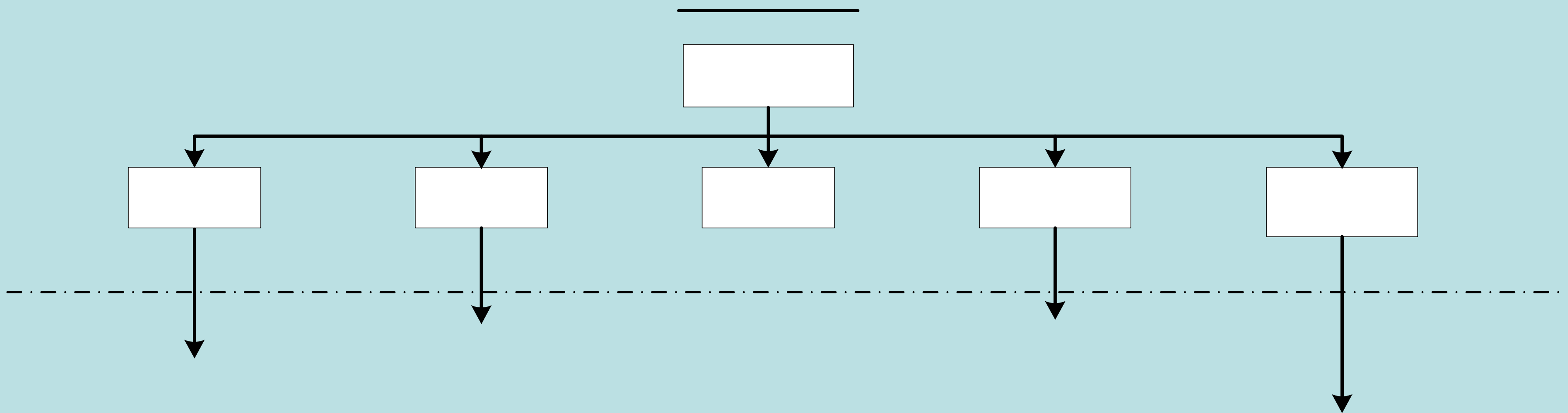
Child Death Review in Manitoba

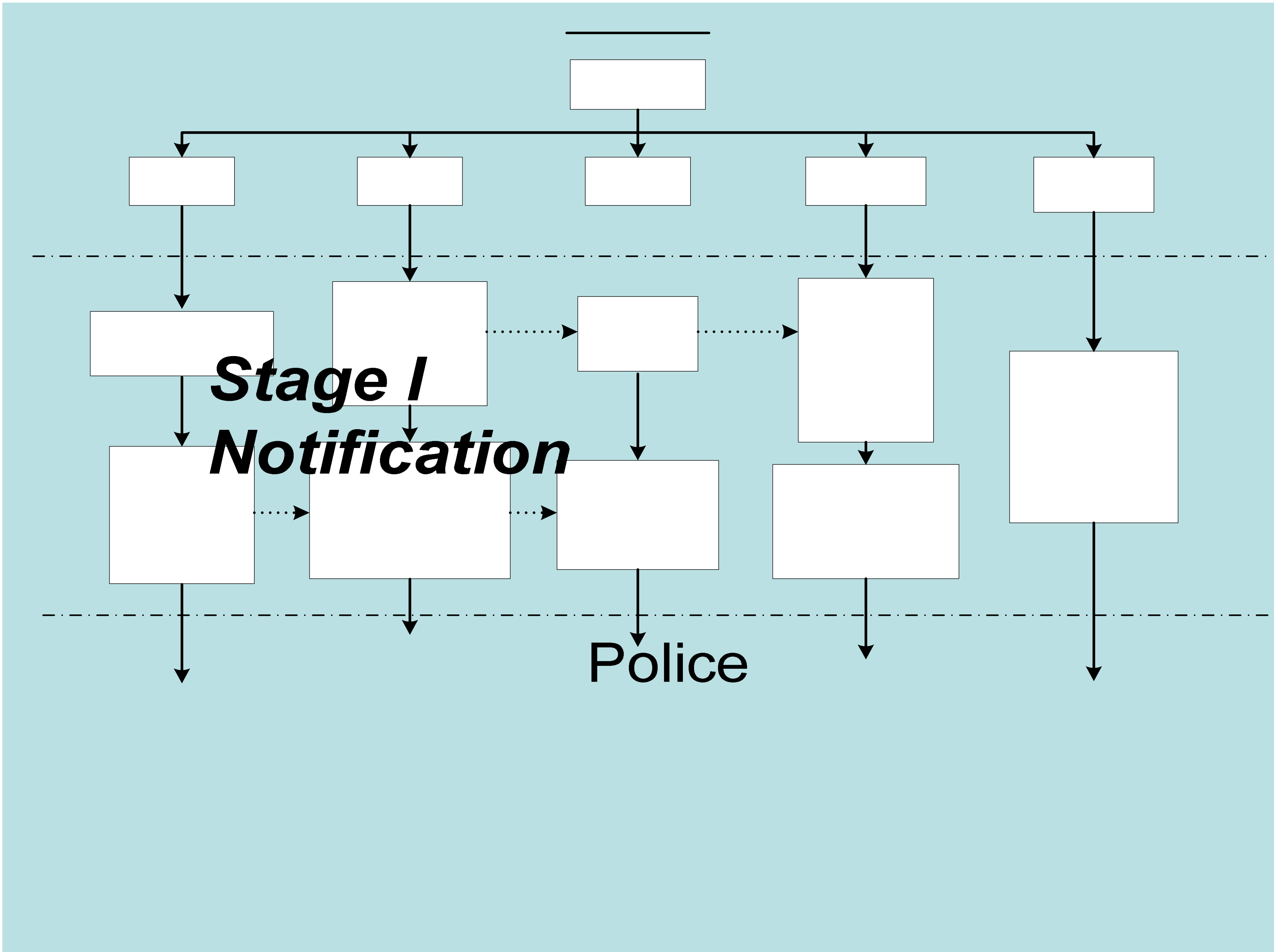
Jan Christianson-Wood, MSW, RSW
Special Investigator
Office of the Chief Medical Examiner



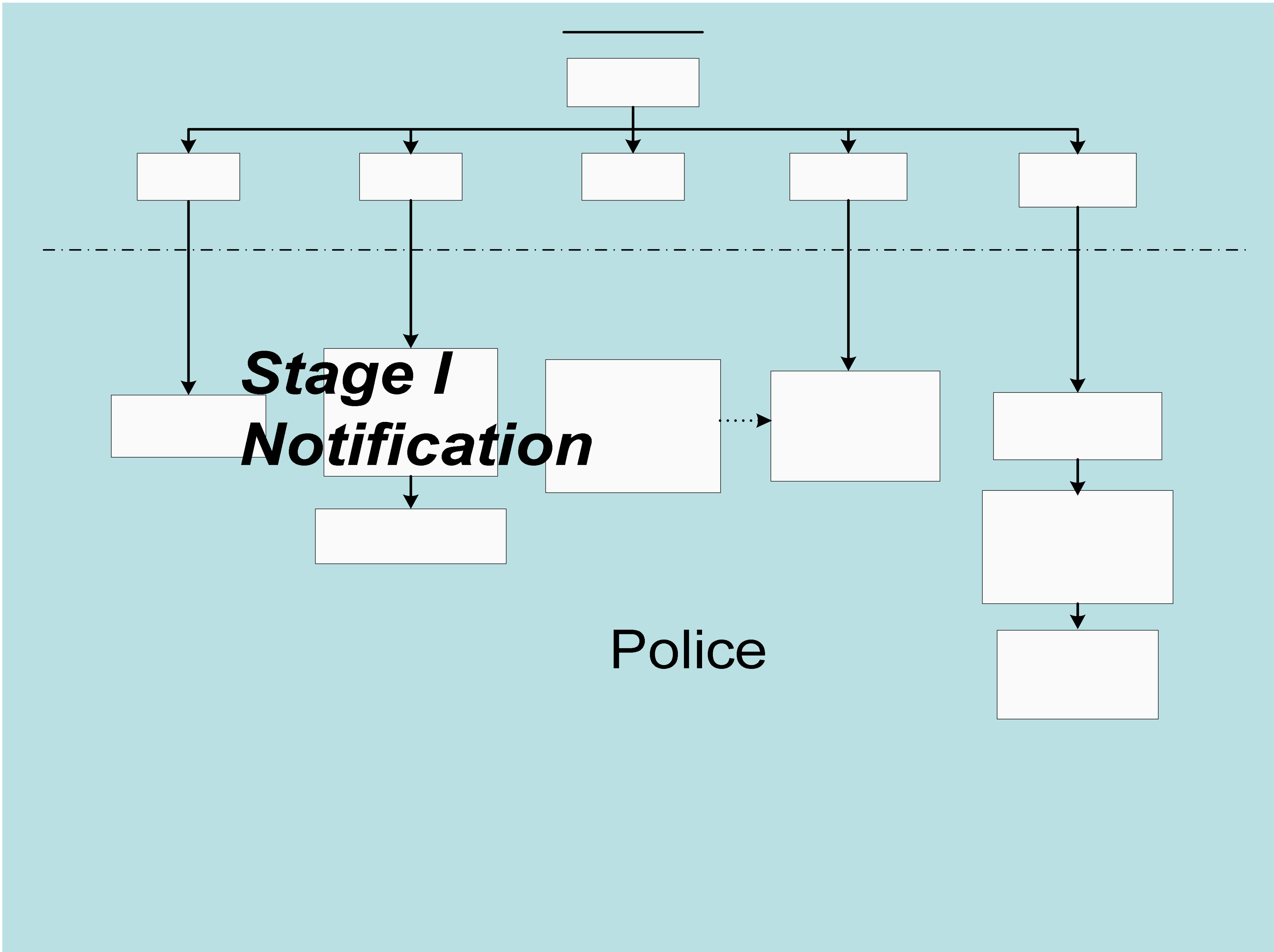
On behalf of

Investigatio

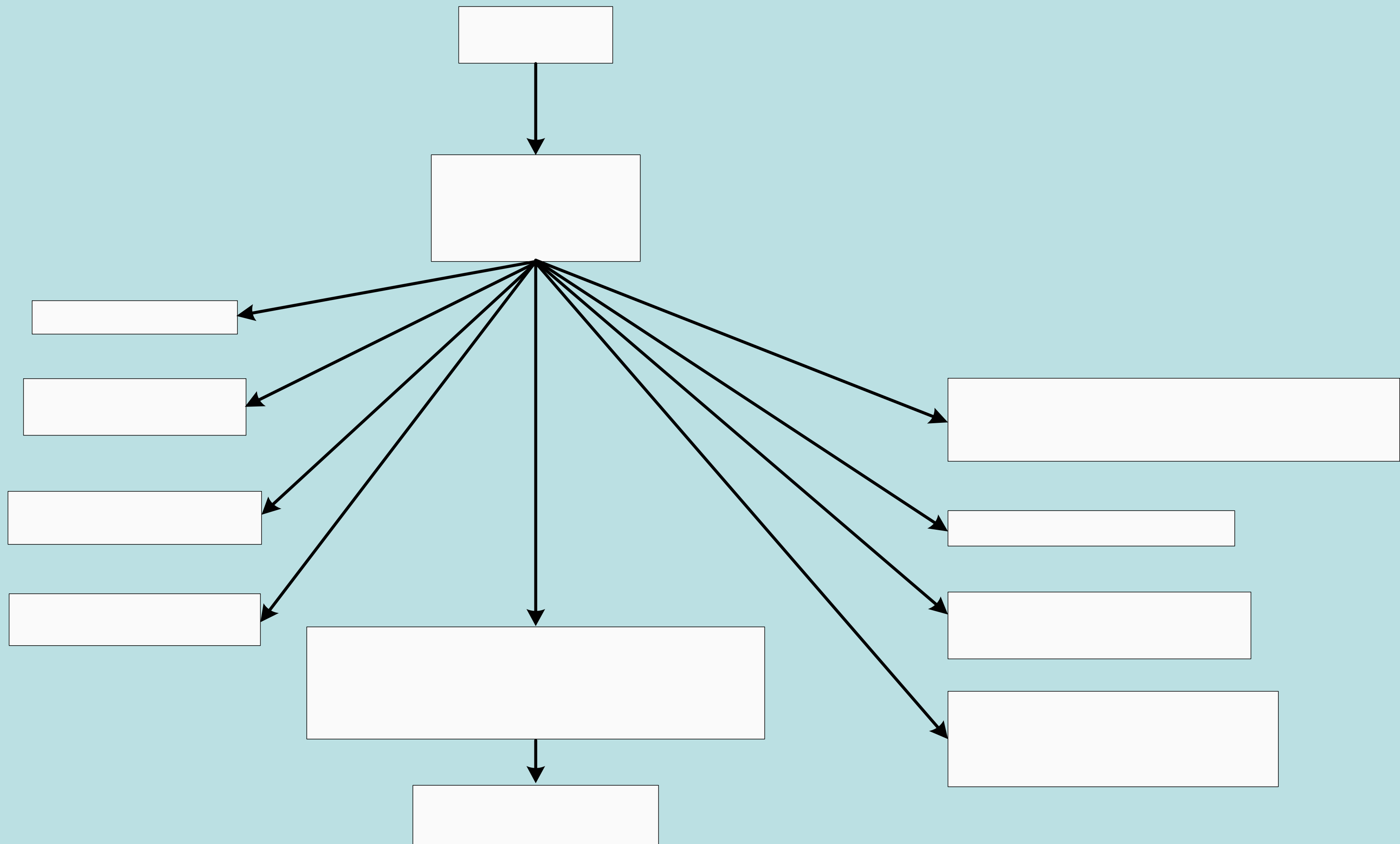




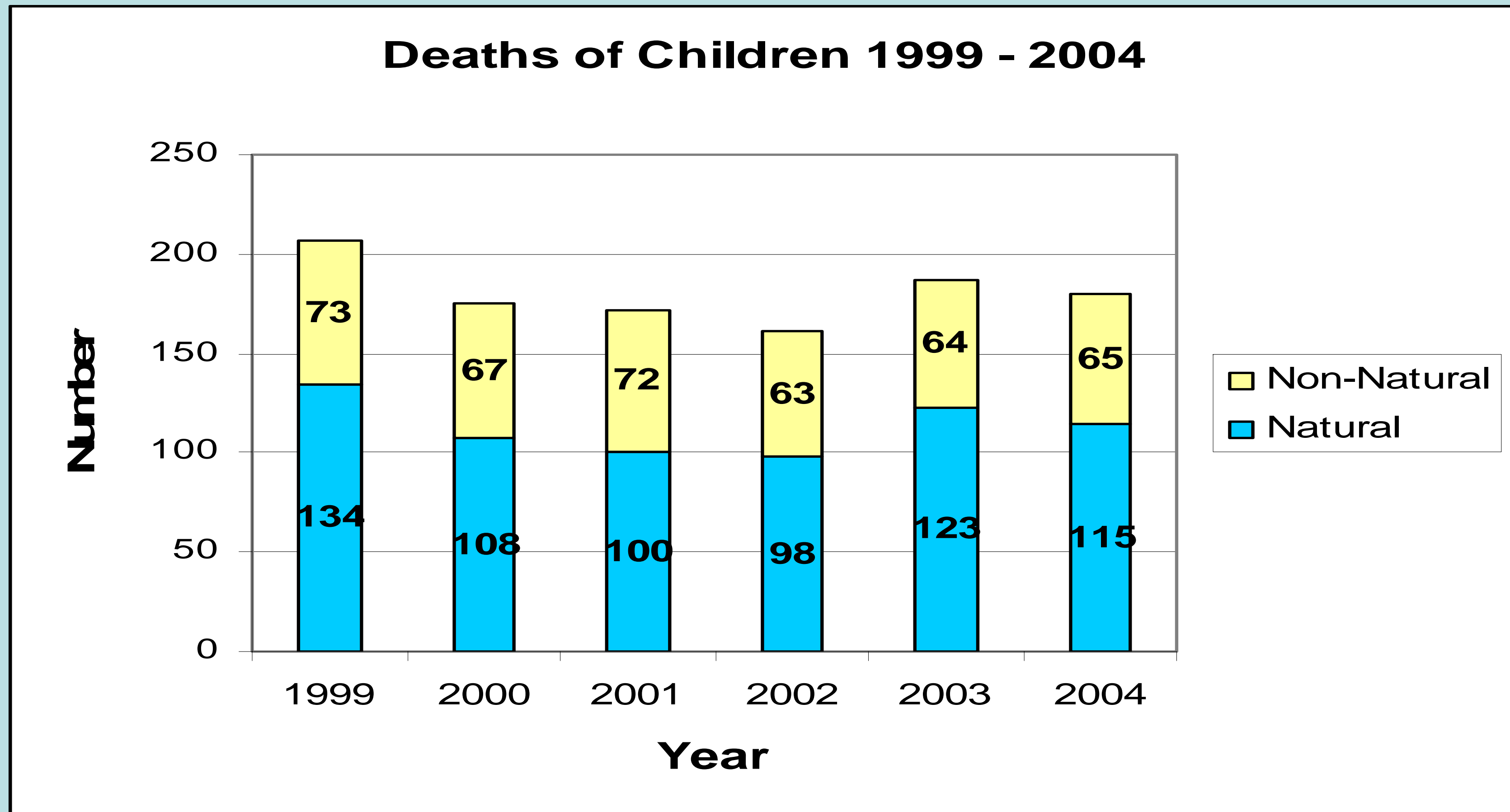
Stage I
Notification
Police
Cl
Inquiry



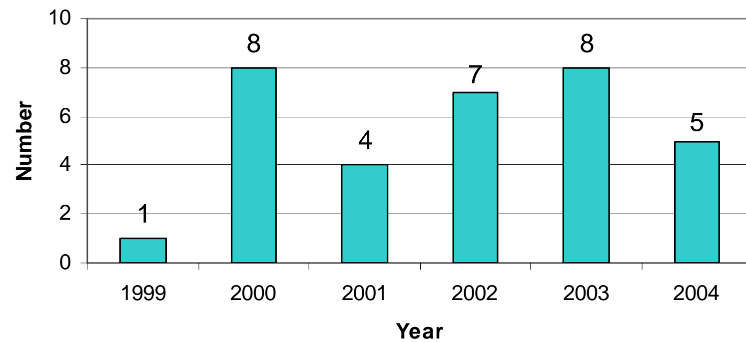
Stage I
Notification
Police
Cl

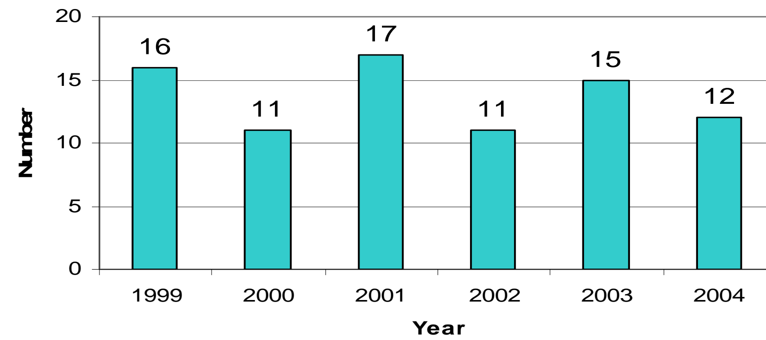


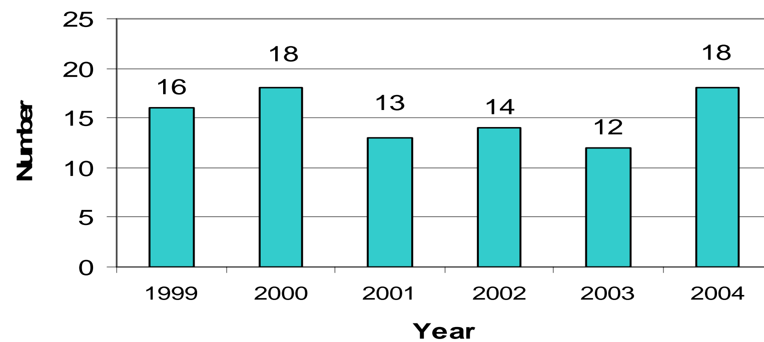
Cases Reviewed by Children's Inquest Review Committee (CIRC)

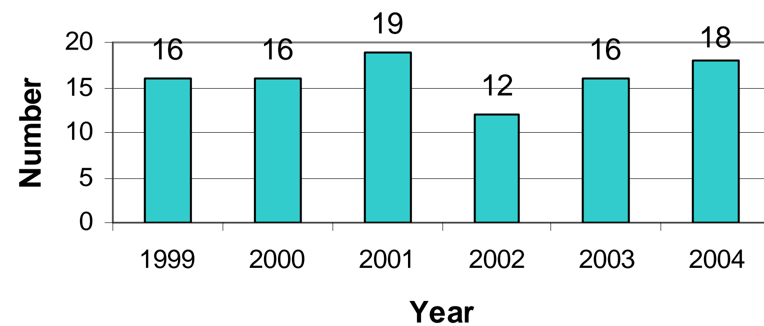


Children's Deaths in Manitoba

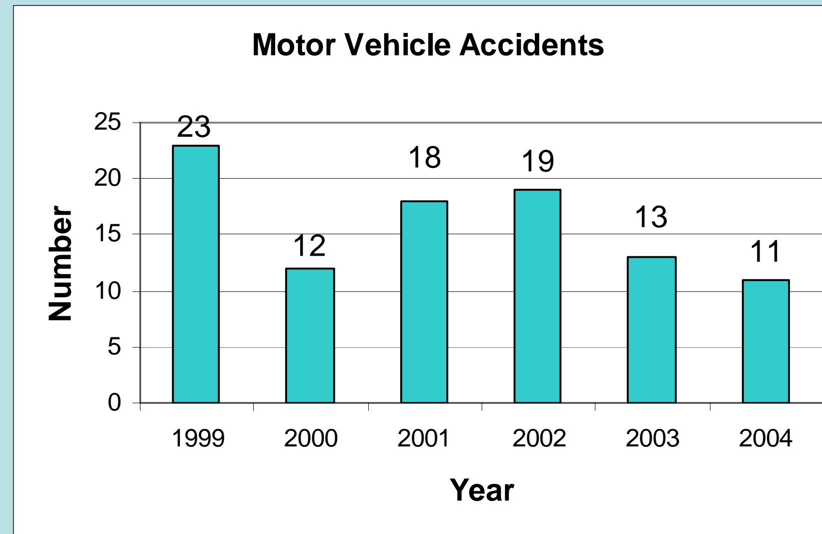








Children's Deaths in Manitoba (cont.)



Children's Inquest Review Committee

- Chief Medical Examiner
- OCME Director
- Special Investigator
- Sgt. Winnipeg Police Service, Child Abuse
- RCMP Crimes Analyst
- Director, Child Protection Branch
- Issues Specialist, Child Protection Branch
- Pediatrician (Child Injury Specialist) for the College
- Pediatrician, Child Protection Clinic, Child Abuse Specialist
- CFS Advisor, Assembly of MB Chiefs
- Children's Advocate
- Pediatric Pathologist

Section 10 Reviews, Fatality Inquiries Act

- Provision under the Act for independent review of services to children by mandated CFS Agencies in Manitoba
- Reviews conducted from Agency records and interviews by OCME Special Investigators (2)
- Recommendations focus on improving service to specific families, program changes, adherence to existing standards, proposed changes to standards and/or legislation
- Child welfare environment in Manitoba is changing rapidly during the Aboriginal Justice Inquiry Child Welfare Initiative implementation

Child Death Reviews and Child Mortality Data Collection in Canada

(with Jane Lothian Murray)

Funded by Health Canada's Child Maltreatment Division, this 1999 survey research provided a 'snapshot' of how child maltreatment deaths were dealt with across the country. Chiefs of Police, Chief Coroners/CME's, Directors of Child Welfare and Children's Advocates were surveyed.

- Canada lacked common definitions and no national statistics on deaths from neglect.
- Recommendations included building a system of national data collection using common data elements extracted from existing child death databases.

Canadian Best Practices Guidelines for Child Death Investigation and Review

- For the purposes of death review, a child should be considered any person under the age of 18 years.

REPORTING OF CHILD DEATH

- All child deaths should be reportable to the coroner or medical examiner; this includes natural deaths, whether they occurred in the hospital or at home.

- The child & family service agency or department in the province or territory should be notified of all unexplained or unexpected child deaths, to determine a history of involvement with child & family services.

CHILD DEATH REVIEW TEAMS

- Multi-disciplinary
- Membership
- Standard form/questionnaire completed for every child death reviewed by the team
- Criteria for panel's review should be specific but not limited.
- Public report on the findings and recommendations of the team.

- All child deaths in a province or territory should be investigated by at least one specially trained investigator, under authority and supervision of the Chief Medical Examiner or Chief Coroner.

- The special investigator for child deaths should attend at the scene of the death, wherever possible.

- If the death is of a child less than two years of age, unexpected and unexplained, special investigator should attend before the body is released or transported and, if need be, should pronounce the death.

- A manual outlining the process for investigation, a minimum set of information to be collected, as well as the method of recording, storing, retrieving and distributing this information.

- Should include standard data forms for information collection

- As much as possible, within the restrictions of the legislation, provinces and territories should strive for uniform approaches to data recording to facilitate sharing, comparison, and distribution of information.

- All child death investigators should receive specific education and training in the task of investigating child death.
- Participants on the Child Death Review Team should also receive education and training on the aspects of child death investigation relevant to their tasks.

- At a minimum, all children under the age of two years, who die in a sudden, unexplained manner, must have an autopsy.
- The autopsy must be complete, with examination of all three body cavities, total body x-rays, histology and toxicology.
- All autopsies on children should be conducted in a centralized facility by a forensic pathologist or, where possible, a pediatric forensic pathologist.

- Each province and territory should develop inter-agency policies, protocols or agreements on information sharing and cooperation in child death investigation.

PUBLIC REPORTING

- Annual reports on child deaths should be published for the purposes of indicating possible trends, making the results of death reviews part of the public record, ensuring that recommendations are followed-up on, and, facilitating comparison within and between jurisdictions.

INVESTIGATION ON STILL-BIRTHS

- In those provinces and territories where still-births as “persons” are excluded from the criteria for reportable death or death review, they should be dealt with as a separate category.

DEATH SCENE

- Wherever possible, the special investigator for child deaths should attend and do the death scene investigation.
- A comprehensive, standardized data-collection form, detailing the type and amount of information to be collected about the child, the circumstances of death, caretakers, the condition of the home, etc. should be used.
- Protocols for dealing with the bereaved family/caregivers, as well as the other scene investigators, should be developed and used in the death scene investigation.

- The child's medical history, including physical and mental health, should be obtained from family, hospital and physicians, and reviewed.

- The physical and mental health history of the child's parents/caregivers and siblings, where relevant, should be obtained and reviewed.

- The child’s and the child’s family involvement with Child and Family Services (child welfare/protection) agencies should be investigated. Information about the action taken and the follow-up to that action should be ascertained.

- Information about the child's living environment and history should be obtained for a complete picture of the circumstances surrounding the child's death. This includes information about the child's family situation, child-care history, housing, school, practice of faith, etc.

Child Death Review Overview

Multi-agency Review of Suspicious/Preventable Child Death

QUIZ …#?

- Child Death Review Team?
- Not Team – Case, Fatal Family Violence
- Funeral or grave with child/client

Child Death Review

- Multi-agency
- Inclusive Intake
- Systematic

Child Death Review, Ignored until 1990s

- 1860s - Ambroise Tardieu described fatal abuse but - he was ignored

- 1965 Child abuse - Index Medicus
- 1970s Child Abuse Prevention (e.g. CPS)
- 1978 Los Angeles County Child Death Review
  - San Diego 1982
  - Other States 1986+
- 1980s Child Sexual Abuse
- 1990s More states, Australia, Canada
- 2001 All States, New Zealand,
- 2005 Philippines

Pages Viewed - ican-ncfr.org - 1/1/02 - 10/15/05*

*actual counts are higher but not captured

3 CANADA
1 US
13 MEXICO
16 BRAZIL
15
2
4
6 NETHERLAND
11 BELGIUM
8 GERMANY
14 POLAND 9
12 ITALY
10 ISRAEL
5 JAPAN
16
Team beginning in the Philippines
7 AUSTRALIA

# pages viewed	# COUNTRIES
100,000+	1
10,000+	3*
1,000 to 9,999	14
100 to 999	40
10 to 99	47
1 to 9	4
None	69**

* The Europian Union as a separate entity has the second highest number of pages viewed.

** Primarily countries with small population...
7 have less than 10,000 (1 under 100)
33 more have less than 1 million
21 more under 10 million
8 more under 20 million

Michael Durfee MD michaeld55@aol.com ICAN-NCFR

Teams in Place
US
Canada
Australia
New Zealand

RANK
Top 3 (5-6 digits)
4-10 (4 digitsd)
11-18 (4 digits)

19- 60 (3 digits)
Czech Republic
Hungary
Morocco
Saudi Arabia
Norway
New Zealand
China
Norway
Iran
Singapore
Austria
Greece
Hong Kong
India
South Africa
Sweden
Russian Fed
Pakistan
Portugal
Philippines
Malaysia
Thailand
Denmark
Romania
Algeria
South Korea
Argentina
Estonia
Uruguay
Seychelles
Belize
Cyprus
Columbia
Lithuania
Ireland
Egypt
Iceland
Nigeria
Croatia
Indonesia
Lebanon

Overview - Child Death Review

- 1 Team Review
- 2 Data
- 3 Prevention
- 4 Grief
- 5 Variation

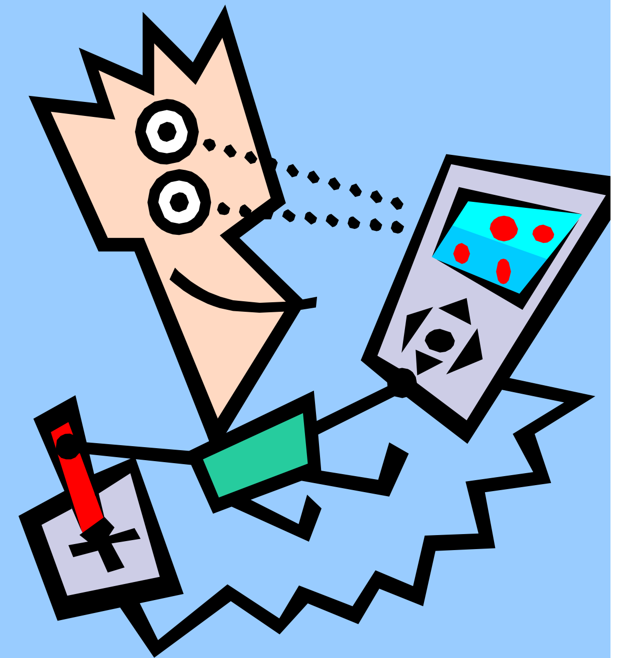
- Cases

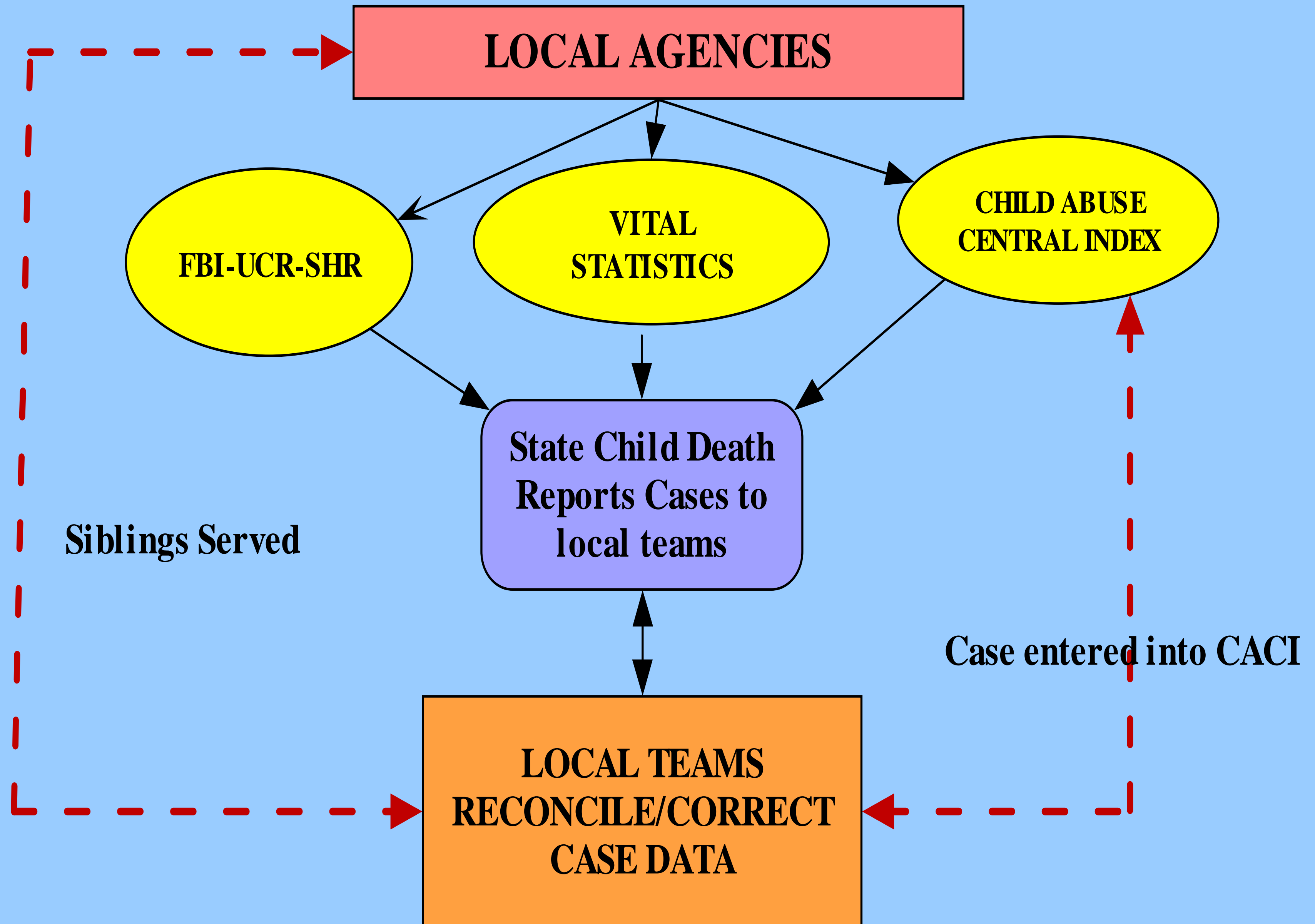
1 Team Review

- <u>Members</u> (Not One Agency)
  - Criminal justice (coroner/ME, LE, DA)
  - Human services (CPS, Health, MH, School
- <u>Inclusive Intake</u> (NOT CPS Only)
  - All deaths or all injury death (small counties)
  - Prospective or retrospective (large counties)
- <u>Review</u>
  - Talk to each other
  - Share Records

2 Data and Reports

- Data
  - improve case management
  - policy and protocols
- Reports can
  - educate the public

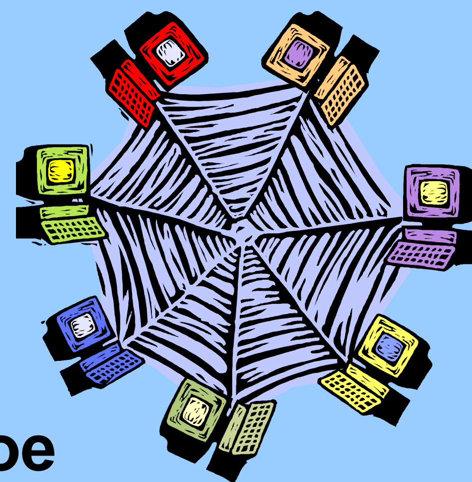



LOCAL AGENCIES
FBI-UCR-SHR
VITAL STATISTICS
CHILD ABUSE CENTRAL INDEX
State Child Death Reports Cases to local teams
Siblings Served
Case entered into CACI
LOCAL TEAMS RECONCILE/CORRECT CASE DATA

3 MAT >>> SAT case management

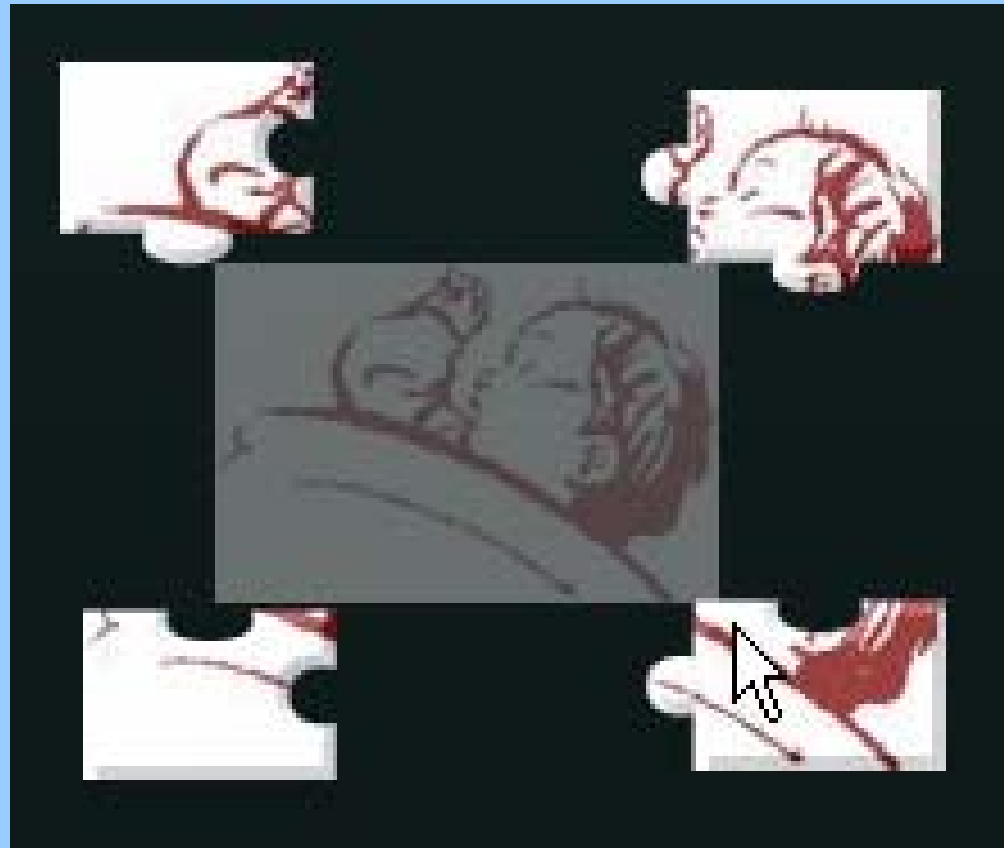
- Particularly for special issues
  - Infants,
  - child perpetrator, multiple perpetrators
  - Undetermined cause
  - Old records
  - Child <u>and</u> DV fatality
  - Multiple jurisdictions

  - For example…Toddler Lake Tahoe
    - fall off couch, coma, hosp… Reno Nevada



FBI UCR SHR - Dad suspect
(Local Police)

Coroner- Undetermined
(neighboring state)



Child Abuse Central Index,
No Report (Local CPS)

Suspicious Death
(local Child Death Review Team)

Most of team connected…

Team finds Coroner
In neighboring state
Tell law enforcement

Conviction, but no CPS referral

Dad convicted but no one reports to social services

Three siblings left in home

Matching data sets identifies missing records
Siblings found and served

4 Grief and Mourning child and other survivors…

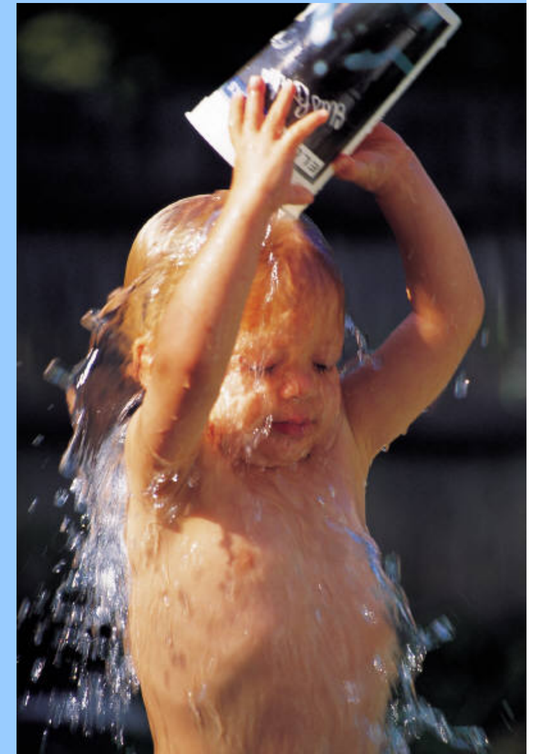
- Child survivors ignored, particularly:
  - Young
  - Compliant
  - Special, foster, delinquent
- Denied –
  - funeral,
  - memorabilia,
  - support

5 Join, different Death Review

- State, local, and regional teams
- Fetal Infant Mortality Review FIMR
- SIDS, SUIDS
- Domestic Violence Fatality Review
- Elder Abuse Fatality Review

Things to do

- Attend a funeral/visit a grave
- Remember someone you lost
- Visit ican-ncfr.org
- Email Michaeld55@aol.com



Know Domestic Violence Fatality Review

cases

- Me no breathe,
- Baby sitter
- Multiple records
- Shower
- 5 y/o perp
- Multijurisdiction