DEATHS OF CHILDREN KNOWN TO SOCIAL DEVELOPMENT 2010-2016 – AN OVERVIEW

December 20, 2017

The Child Death Review Committee (the Committee) was transferred to the Chief Coroner's Office in December 2009 from the Department of Social Development. The Committee is chaired by the Deputy Chief Coroner and acts in an advisory capacity to the Chief Coroner. The mandate of the Committee is to consider the facts and circumstances surrounding the sudden and unexpected deaths of New Brunswick children who were under the age of nineteen at the time of their death. All deaths of children in the care of, or receiving services from the Minister of Social Development at the time of their death or in the previous 12 months must be referred to the Committee.

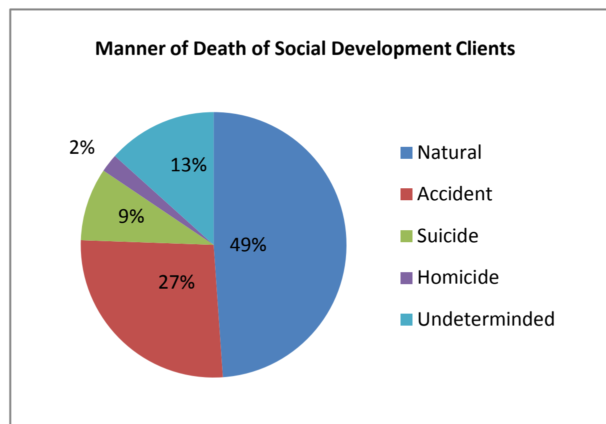
During the period 2010-2016 Social Development reports an annual average of 17 389 child clients. There were 45 children who died while they were either in the legal care of the Minister of Social Development(2) or who were receiving services at the time of their death or had received services within the 12 months previous to their death. This represents 0.4 deaths per 1000 child clients known to the Minister each year.

Child Deaths by Manner of Death, 2010-2016

	2010	2011	2012	2013	2014	2015	2016	Total
Natural	1	2	5	1	3	3	7	22
Accident	5	0	2	0	3	2	0	12
Suicide	1	0	0	0	1	0	2	4
Homicide	0	0	0	0	0	1	0	1
Undetermined	0	0	0	2	0	2	2	6
Total	**7**	**2**	**7**	**3**	**7**	**8**	**11**	**45**

Of the 45 deaths, 32 of those cases were the subject of an investigation by the coroner. The remaining 13 were either natural deaths (8) that did not meet the criteria for reporting to the coroner for investigation or the deceased died in another province in which case the coroner did not have jurisdiction to investigate. There were five such deaths.

The chart shows the breakdown of manner of those deaths. Twenty –two or 49% were classified as natural, 12 (27%) were accidents, 4 (9%) were suicides and 6 (13%) were undetermined. There was one homicide during this report period.



Natural deaths included causes of death such as complications associated with neurological/neuromuscular conditions (7), genetic and congenital defects (5), infections (3), and cancer (1) among others. Accidental deaths were primarily motor vehicle collisions/upsets (7), accidental asphyxia (2), drowning (1), drugs (1) and from structure fires (1). All four suicides were as a result of ligature hanging and the single homicide was as a result of stab injuries. Five of the six undetermined deaths were of infants under the age of 1 year where no anatomical death could be determined (Sudden Unexpected Death in Infancy or SUDI). Bed-sharing was an identified risk factor in 4 of the 5.

There were 27 male (60%) and 18 female (40%) children who died during the years 2010-2016. This is consistent with the division seen in coroner investigated deaths.

The age distribution is indicated in the chart which shows that a quarter of all social development client deaths were of those under one year of age. There were 9 (20%) deaths in the 1-4 year cohort and 6 each (13%) in the 5-9 and 10-14 year age ranges. In the 15-18 year range there were 13 (29%) deaths.

There were 35 deaths that were reviewed by the committee. The 10 that were not reviewed were natural deaths and under the terms of reference of the Committee, the chair came to the conclusion, based on the circumstances of death that a review was not warranted. Fourteen (14) reviews resulted in 26 recommendations being made. All recommendations to date have been responded to.