New Brunswick Coroner Service
Office of the Chief Coroner

Terms of Reference
Child Death Review Committee

The Child Death Review Committee is a permanent advisory committee to the Chief Coroner.

MANDATE
The mandate of the Child Death Review 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.

MISSION
To conduct comprehensive reviews of all child deaths reported to a coroner in New Brunswick in an effort to understand how and why children die and using this information to take action to prevent future deaths and improve the health, safety and well-being of all children in New Brunswick.

PROCESS
This is accomplished by a staged review process. In Stage 1 the Committee will be notified on a monthly basis of all child deaths in New Brunswick for which the coroner seized jurisdiction and conducted an investigation. The information provided will include the date of birth, date of death, the death factor, the cause of death statement, the district in which the death occurred, the status of the investigation and, when finalized, the manner of death. The Committee may recommend, through the Chair, that the Chief Coroner refer a specific case(s) for review by the Committee.

The Stage 2 review will be a full committee review of a specific death. All deaths of children who, at the time of their death, were receiving services or their parents were receiving services from and/or were in the care of the Minister of Families and Children within the last twelve months and any other death at the discretion of the Chief Coroner will be referred to the Committee for a full review. The chairperson shall have discretion as to whether or not a child who has died of natural causes will be subject to a full review.

The objectives of the Committee shall be:

- To review the manner and cause of death
- To comment upon relevant protocols, policies and procedures, standards and legislation as to whether they were followed and as to their adequacy.
- To comment upon linkages and coordination of services with relevant parties as to whether they were sufficient and adequate.
- To make recommendations that would lead to improvements in order to prevent future deaths and improve the health, safety and well-being of New Brunswick children
- To submit a written report within 60 days of a referral of a death from the Chief Coroner and shall include information as detailed in Appendix A. The chief Coroner may extend the 60 day time period upon the written request of the Committee chair.

The membership of the Committee shall be appointed by the Chief Coroner as follows:

- A person appointed as a coroner for the Province of New Brunswick. This person shall be the Chairperson.
- A Police Officer.
- A Paediatrician.
- A University Social Work professor nominated by the Director of the Social Work Department of a New Brunswick University.
- A representative from the Aboriginal community
- A Lawyer
- A Pathologist

Other individuals/professionals may be invited by the Committee on an ad hoc basis to assist in the conducting of reviews.

The Chief Coroner may remove any member from the committee for cause including, but not limited to, a breach of the Oath of Confidentiality, conduct unbecoming a member of a professional committee and amendments to the terms of reference of the Committee such that changes to the membership are warranted.

Vice Chairperson

In order to ensure continuation of the functionality of the Child Death Review Committee, the members of the Committee in agreement with the Chairperson shall select from amongst its members a Vice Chairperson to serve as Chair when the Chairperson is not able to preside at a meeting of the Committee.

Limitations

- The review must not interfere with any police investigation or Coroner's inquiry, but the review could operate concurrently.
- The Committee provides advice only to the Chief Coroner and may make recommendations through the Chair to the Chief Coroner.
- Committee members who may have had previous involvement with the child or family will not participate as committee members.
- Committee minutes, reports and correspondence will be governed by the *Right to Information Act* (and any subsequent legislation hereof), the *Protection of Personal Information Act* (and any subsequent legislation hereof) and the *Coroners Act.*
- Members shall treat all discussions and information regarding individual cases in a confidential manner. Members are required to sign an Oath of Confidentiality to that effect.
- The Committee has no authority to make findings or to make recommendations regarding the conduct of individual employees which could relate to discipline of employees or their status as employees.

Responsibilities of the Chief Coroner

- Continually update the Coroner Service Child Death Monthly Dashboard and provide to the Committee on a monthly basis.
- Refer appropriate cases to the Committee via the Chair in writing once the investigation is complete and in the case of a Families and Children client, within 10 days of receipt of the Minister of Families and Children's Regional Report into the Death of a Child.
- Upon receipt of the final report from the Committee, within 15 days, forward the report with recommendations, if any, to the relevant government departments for response. At the same time provide a copy to the report to the Child and Youth Advocate.
- Within 30 days of receipt of the report make public the recommendations including an anonymized summary of the circumstances of the death to provide context.
- Monitor responses to the recommendations and request updates as required to ensure complete accountability.
- Publish an annual reporting of the work of the Committee including a statistical review of all child deaths reported to the coroner for that calendar year.
- Upon the recommendation of the Committee through the chair, the Chief Coroner may refer a particular case or cases to the Child & Youth Advocate for a more in depth review or investigation.

Roles and Responsibilities of the Minister of Families and Children

- The Minister of Families and Children, shall, immediately upon being notified of a death of a child in his care or having received services in the previous 12 months, notify the Chief Coroner in writing that a death has occurred and that a Regional Review into the Death of a Child has been initiated.
- The Minister of Families and Children shall provide a copy of the Regional Review into the Death of a Child report and any other relevant documents within 30 days following the death.
- The Minister of Families and Children shall provide access to all relevant documents and records, all individuals, all employees of the Department and service providers involved in providing services or care to the subject of the review, at the request of the Committee.
- Upon receiving the recommendations of the Committee from the Chief Coroner, the Minister of Families and Children will have 45 days to publicly respond to recommendations.

These Terms of Reference shall be reviewed by the Chief Coroner in consultation with the Chair of the Committee annually during the month of September. The committee may submit recommendations to amend the terms of reference to the Chief Coroner through the Chair.

Appendix A - Report Format

Introduction

- Critical Issue

Review Process

- Purpose
- Method
- Documents reviewed
- Personal interview
    - Internal
    - External

Background

- Significant case history

Review Findings

- Sequence of events
- Critical issues
- Policy/Case practice
- Other factors for consideration

Conclusion

Appendices