Nova Scotia's

Child Death Review Committee (CDRC)

Terms of Reference

DRAFT DATE: March 2023

Note: Nothing in this document supersedes legislation or regulation

Table of Contents

LEGISLATED MANDATE

The mandate of the Child Death Review Committee (CDRC) is provided under the *Fatalities Investigation Act (FIA)*, and accompanying Death Review Committee Ministerial regulations.

The *Fatalities Investigation Act (FIA) through Bill 180*, and accompanying regulations, provides that mandate of the Committee is:

- Reviewing aggregate, population-level information regarding deaths of persons under twenty-five years of age to find trends and inform prevention programs;
- Reviewing the facts and circumstances relating to specific child deaths;
- Providing advice and recommendations to the Minister respecting the prevention and reduction of (i) deaths of persons under twenty-five years of age; (ii) child deaths; and
- Performing other duties and functions as prescribed by the regulations.

SCOPE

The Committee has three main functions:

Population Level Data Analysis: Examine trends in deaths of all young persons in the province under 25 years old explore how data may be used with a prevention focus to inform programs and policies

Individual Case Analysis: Conduct multi-disciplinary in-depth case reviews of the individual deaths of those under 19 who die in circumstances referred to in Section 9 of the FIA while in the care and custody of the Province. The Committee may review one or more deaths during an individual case review.

Assessment of Data: As per section 13 of the regulations, no later than 18 months after the regulations come into force, the Committee must provide the Minister with an assessment of available data on critical injuries sustained by children in Nova Scotia and a recommendation as to how the available data may inform the committee's work.

The Minister may, in consultation with the Chief Medical Examiner, direct the Child Death Review Committee to review the facts and circumstances of other deaths of persons under nineteen years of age that occurred under a circumstance referred to in Sections 9 to 12 of the FIA.

INFORMATION AND PROTECTION OF PRIVACY

CONFIDENTIALITY

The FIA provides that a member of a committee shall not publish or disclose information acquired in their role as a committee member to anyone, whether during or after their appointment, except as provided in the FIA.

Each Committee member and guest will be required to sign a confidentiality agreement, re-iterating requirements contained in legislation with respect to protection of privacy.

PRIVACY IMPACT ASSESSMENT

It is the responsibility of the Chair to consult with Privacy Specialists at Service Nova Scotia and Internal Services with respect to operational requirements for Privacy Impact Assessments (PIAs).

PIAs with respect to the Death Review Committee's work are required to be kept current and may be reviewed on an annual basis or as required.

INFORMATION USE, DISCLOSURE AND STORAGE POLICY

Information shall be used, disclosed and stored in accordance with legislation, applicable privacy impact assessments, and the Province's Information Management Policies.

COMMITTEE STRUCTURE & OPERATIONS

Committee Membership

Position
(1) Chair, Chief Medical Examiner (CME)
(2) Public Prosecution Service (Crown Attorney)
(3) Police Officer, recommended by the NS Association of the Chiefs of Police, experience at the major crimes level and the Joint Protocol Training from DCS
(4) Chief Medical Officer of Health
(5) Pediatrician
(6) Mi'kmaw representative
(7) African Nova Scotian representative
(8) Immigrant community representative
(9) 2SLGBTQ+ community representative
(10) Community Services (Child Protection) – director level or above
(11) Justice (Correctional Services) – director level or above
(12) Education and Early Childhood Development – director level or above

(13) Health and Wellness, Executive Lead, Public Health- director level or above
Vice Chair (note: selected from membership)

Other subject matter experts as required may be invited to attend meetings on an ad hoc basis

Committee Member Roles and Responsibilities

Chair, Chief Medical Examiner (CME)

- As per s.39E(6) of the FIA, consult with the Minister on the designation of a vice-chair
- Ensure Privacy Impact Assessments are conducted as necessary
- Report to the Minister as required, on behalf of the Committee
- Appoint any members to the committee that are not civil servants
- Act as spokesperson, including any communication required with next of kin
- Monitor Committee objectives and overall progress
- Advise the Minister upon commencement of an individual case review
- Upon completion of individual case reviews, ensure final reports are submitted to the Minister
- In consultation with the Public Prosecution Service, ensure a death review respecting a specific death does not interfere with a criminal investigation or prosecution

Vice-Chair

- Perform duties of the Chair in their absence

Staff Support

Epidemiologist

- Staffed in the CME Office, under the guidance of the CME provides epidemiological support to the committee.

Terms of Membership

As per Regulations:

- Membership terms expire every three years. There is no limit to the number of times that committee members can be reappointed.
- Membership may be revoked by the person who made the appointment, or their successor.

Manner of Appointment

- Civil servant members are appointed by the Deputy Ministers from their respective Department.

- Non-civil servant members are appointed by the Chair.
- The Chair will issue appointment letters to non-civil servant members, outlining the date of the appointment and expiry (three-year term).

Renumeration and Expenses

As per section six of regulations, committee members not employed in the public service or not otherwise receiving compensation from their employer for their participation on the Committee, must be paid $125 for each half day or $250 for each full day of participation in duly called Committee meetings.

Members are entitled to be reimbursed for actual and reasonable expenses they incur in the discharge of their duties, but reimbursement for those expenses must not exceed that normally payable to members of the public service.

Conflict of Interest

Committee members who may have had previous direct involvement with a child whose death is the subject of the Committee's review, or the child's family, will not participate as committee members on an individual case review.

It is the responsibility of committee members to declare a conflict of interest and bring it to the attention of the Chair.

Reporting Structure

As per the *Fatalities Investigation Act,* the Committee reports directly through the Chair to the Minister of Justice.

DECISION MAKING PROCESS

- Decisions will be made based on consensus, whenever possible.
- Consensus means that all committee members agree.
- If consensus cannot be achieved, the Chair may choose to put matters to a majority vote. All committee members will be voting members.
- As per regulations, a Committee must not approve the Committee's final report in the absence of a quorum.

QUORUM

As per regulations:

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- Two-thirds of the members of a Committee constitute a quorum.

DELIVERABLES and REPORTS

1. Assessment of Data: as per section 13 of the regulations, no later than 18 months after the regulations come into force, the Committee must provide the Minister with an assessment of available data on critical injuries sustained by children in Nova Scotia and a recommendation as to how the available data may inform the committee's work.

2**.** A detailed written report to the Minister, following each individual case review, as per section 39G of the FIA(refer to Appendix A for report format).

3. A de-identified summary and recommendations report, provided to the public by the Minister, following each individual case review, as per section 11 of the regulations. This will form the executive summary of each detailed report referenced above.

4. An annual public report, as per section 12 of the regulations, to the Minister every year for publication, that includes a description of trends and a summary of the Committee's recommendations for system improvements.

REVIEW OF TERMS OF REFERENCE

This Operating Policy will be reviewed after one year of the Committee's operation, at which time a review schedule will be established.

LIMITATIONS

- Subsection 39D (7) of the FIA provides that the Committee shall not conduct a death review until the Medical Examiner has completed their duties.
- Subsection 39G(2) of the FIA provides that the Committee's reports must not include any findings of legal responsibility or conclusions of law.
- Section 39F of the FIA, a death review may not interfere with a criminal investigation or prosecution.
- 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.

APPENDIX A – Information to be included in individual case reviews

Introduction

- Critical issue

Review Process

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

Background

- Significant case history

Review Findings

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

Conclusion

Appendices

APPENDIX B- Death Case Review Process

STEP 1: Committee Notification

- Committee members will be informed of a death that requires an individual case review in one of two ways:
  1. By the Chair at a Committee meeting
  2. By individual Committee members, at a meeting

STEP 2: Notify the Minister of Justice

- CME notifies the Minster of Justice that an individual case review has begun.

STEP 3: Gather Case Relevant Information.

- All Committee members, and the epidemiologist, gather case relevant information. Provide to CME and epidemiologist for review before next meeting.

STEP 4: Case Discussion and Analysis.

- Cases may be brought back to review agendas multiple times, until the team is comfortable that all areas of concern have been properly addressed
- Discuss the Delivery of Services

Questions that need to be asked regarding the delivery of services include:

Were there any services that the family was accessing prior to the death?
Were services provided to family members as a result of the death?
Were services provided to other children (schoolmates, etc.)?
Were services provided to responders, witnesses or community members?
Are there additional services that should be provided to anyone?
Who will take the lead in following up on these service provisions?
Does the team have suggestions to improve service delivery systems?
As with the clarification of the investigative process, these questions are not meant to place blame, but to ensure that those who may be touched by a death receive needed support services.

STEP 5: Identify Risk Factors

Identifying the risk factors involved in a child's death during the review can lead to recommendations that the team believes could reduce those same risk factors for other children, thereby preventing future deaths. Grouping risk factors into general categories can help guide this discussion:

- Health
- Social
- Economic
- Behavioral
- Environmental
- Systemic (Agency Policies and Procedures)
- Product Safety

It is important to identify the risk factors involved in each death, as these become the basis upon which a team will formulate its findings. These findings are in turn used to generate recommendations for improved investigations, service delivery, changes in systems, local ordinance, legislation or community or state prevention initiatives. These systems improvements and prevention programming are the ultimate goal of a CDR process that is based on the public health model, to keep children safe, healthy and protected.

STEP 6: Generate Recommendations and Report

STEP 7: Evaluation
Will the Committee track responses to recommendations made?
How will the Committee measure it's success?