Child Death Review Committee

On June 26, 2026, the Child Death Review Committee provided the Minister of Justice with a review report. The report includes the following advice and recommendations.

ADVICE TO THE MINISTER

We note that, at the time of their death, this child was not legally permitted to drive a motorcycle and so changes in Nova Scotia's licensing framework would not have prevented their death. But in the course of our deliberations, we found that there is some evidence that novice motorcycle drivers enjoy lower crash rates when they are limited to less powerful motorcycles. In Nova Scotia, there is currently no limit on how powerful a motorcycle a novice driver can drive, and we believe that this specific issue should be studied for implementation in Nova Scotia.

RECOMMENDATIONS TO PREVENT SIMILAR DEATHS

Recommendation #1: We recommend that the province's Road Safety Advisory Committee collect and analyse fatal and non-fatal collision data. This analysis should focus on a better understanding of trends, risk factors and priority areas for intervention.

The Committee heard that data about motor vehicle injuries and deaths related to their place and time are not being collected or analysed. This kind of data would help inform safety-related capital improvements to road infrastructure by identifying places where serious accidents are more likely to occur.

Recommendation #2: We recommend the development of a comprehensive, cross-departmental information-sharing strategy that applies to all children receiving services from Child and Family Wellbeing (CFW), including Mi'kmaq Family and Children Services (MFCS). The strategy should include all relevant partners, and the goal of the strategy should be the timely sharing of all relevant information with all parties.

The Committee heard that the quality of this child's care was sometimes inhibited by a lack of timely, basic information sharing. Release plans that would have benefited from coordination between the youth court and DOSD were deficient in important ways.

Recommendation #3: We recommend the development of a comprehensive cross-departmental strategy for the coordination of services for children in care.

The Committee heard that the full range of services available to children in care is relatively comprehensive, but it is difficult for the youth themselves to navigate a system that is complex and siloed. An improvement in information sharing like the one recommended above will help this, but a broader strategy is called for.

Recommendation #4: We recommend that Child and Family Wellbeing (CFW) review their recruitment and retention practices with the broad aim of improving staff turnover and continuity of care.

The Committee heard that the quality of this young person's care was substantially diminished by a lack of trust in the system, which was firmly rooted in the high turnover in front line staff. This young person interacted with many CFW staff and thus had limited opportunity to establish trusting relationships with members of the CFW team. We heard that the cause of this is that the

front-line worker is considered a high-stress, high-turnover, entry level position. This has important implications for the quality of care that CFW may be able to provide and deserves serious reflection and careful reform.