BC Coroners Service

# 2008 Annual Report

## Child Death Review Unit of BC

This report provides a summary of the Child Death Review Unit's work in 2008. It outlines what the CDRU is all about; who we are, what we do and why we do it. It also outlines the progress that has been made on the implementation of recommendations and highlights the upcoming work we will be doing over the next few years.

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# Who we are

The Child Death Review Unit (CDRU) is embedded within the BC Coroners Service; this allows for monitoring of deaths in real-time and improved knowledge transfer between reviewers and investigators of child deaths. The CDRU is supported by legislative authority under the Coroners Act, a budget and full-time employees.

The updated Coroners Act, enacted in 2007, outlines the authorities of the CDRU and provides members of the unit with the ability to exercise the powers of investigation and the authority to obtain additional information necessary to complete their review. The Act also outlines the legislated authority for child death review panels.

The Child Death Review Unit consists of a Director, a Program Assistant and case reviewers with expertise in paediatric medicine; forensics; investigation; child welfare; project management; and injury prevention.

## Mandate

To review, on an individual or aggregate basis, the facts and circumstances related to the deaths of all children 18 years and younger in British Columbia.

## Mission

To conduct a comprehensive review of all child deaths in British Columbia in order to better understand how and why children die, and to use those findings to take action to prevent other deaths and improve the health, safety and well-being of all children in B.C.

# Our work this year

Throughout 2008, the Child Death Review Unit reviewed 431 child deaths that resulted in 34 recommendations to more than 20 government and non-government organizations. Several projects were undertaken, including the publishing of two reports and establishment of two child death review panels. The year also provided the CDRU with opportunities for learning and development, information sharing, and collaboration with other organizations.

Reports released in 2008 included the 2007 Annual Report, which examines child death cases that were forwarded to and subsequently reviewed by the Child Death Review Unit in 2007. The report includes 12 recommendations to nine separate organizations.

Additionally, a special report on child and youth suicide entitled, "Looking for Something to Look Forward To": A Five-Year Retrospective Review of Child and Youth Suicide in B.C. was released. This report provides an in-depth review of the 81 child and youth suicide deaths that occurred during a five-year period (January 1, 2003 and December 31, 2007). It includes information on demographics, circumstances of death, risk factors and services received by the children and youth, in addition to investigating the specific risk factors experienced by Aboriginal children. The report also includes 17 recommendations for the prevention of child and youth suicide in British Columbia. Recommendations were developed by a child death review panel and were based on the findings of the retrospective review.

A second child death panel was convened in 2008 to examine the deaths of six Aboriginal children where alcohol use was determined to be a risk factor. On conclusion of the panel, five recommendations were forwarded to the Chief Coroner. The findings and recommendations of the panel are included in a report released in July 2009; D.C. et al.

In 2008, the Child Death Review Unit began working with the BC Vital Statistics Agency (BCVSA) on a project to enhance the identification and collection of data on risk factors for cases of sudden unexplained infant deaths. Prior discussions between the CDRU, the BCVSA and the Ministry of Healthy Living and Sport highlighted the importance of capturing risk factors associated with these deaths. Eight evidence-based risk factors were selected, including exposure to second-hand smoke and placing an infant to sleep in a position other than on his or her back. To date, the CDRU has reviewed and collected data from 134 sudden infant deaths files dating back to January 1, 1998. Information collected was provided to the BCVSA. This project is ongoing.

# Activities

## Learning

Members of the CDRU participated in a number of conferences, internships, workshops and presentations in 2008.

- BC Perinatal Health Program's Aboriginal Perinatal Health Retreat
- BC Injury Research and Prevention Conference
- B.C. Champions for Children and Youth Summit (hosted by the Representative for Children and Youth)
- Community Against Preventable Injuries workshop: Social Marketing–An Innovative Approach to Behaviour Change
- Internship with Child Death Review Teams in New South Wales and Queensland, Australia
- Indigenous Child at the Centre - Chief's Forum
- Ministry of Healthy Living and Sport-Population Health Surveillance and Epidemiology: Epidemiology of child and youth suicide
- Public Safety and Solicitor General Champions for Change workshop
- Seventh North American Conference on Shaken Baby Syndrome/Abusive Head Trauma

## Educating

On behalf of the BC Coroners Service, the Child Death Review Unit issued two public safety bulletins in 2008:

- Infant Deaths Linked to Unsafe Sleep Practices (March 2008)
- Stats and Studies Show Too Many Kids Victims of Fatal Pedestrian Accidents (in support of Safe Kids Week, May 2008)

Public safety bulletins can be found on the BC Coroners Service website: www.gov.bc/pssg/coroners.

In addition, members of the CDRU gave a number of presentations on the work the unit does, including:

- Aboriginal Perinatal Health Retreat: Report on 2007 Perinatal Findings
- BC Injury Research and Prevention Conference: "Child Death Review - A Catalyst for Prevention"
- Interior Health Ethics Conference: "Child Death Review–Re-traumatizing Families?"
- White Buffalo Aboriginal Health Society Mental Health and Wellness Conference: "Moving from Awareness to Engagement"

# Collaborating

The Child Death Review Unit developed and maintained a number of collaborative partnerships in 2008.

- Aboriginal Perinatal Data Collection and Sharing Committee
- BC Injury Prevention and Leadership Action Network
- BC Injury Research and Prevention Unit
- BC Perinatal Health Program
- Children's Forum
- The Community Against Preventable Injuries
- First Nations Health Council
- Fraser Health Authority- Quality Improvement and Patient Safety
- Ministry of Children and Family Development
- Ministry of Healthy Living & Sport- Population Health Surveillance & Epidemiology
- National Center for Child Death Review (U.S.)
- Office of the Representative for Children and Youth
- Safe Kids Canada
- Shaken Baby Syndrome Steering Committee
- SIDS Foundation of Washington

# Our process

The review process used by the Child Death Review Unit is based on best practices for child death review from across North America and was developed with guidance from the National Center for Child Death Review in the United States.

The review process consists of three main components: case reviews; recommendation development, monitoring and implementation; and reporting on our activities and review findings.

# Case reviews

Case review is a key component of the child death review process. The information that is obtained and considered through case review forms the basis of the Child Death Review Unit's work, from providing information to child death review panels to developing strong recommendations that aid in the prevention of future child deaths.

Every child death in B.C. is reviewed by the CDRU, including both sudden and unexpected deaths and those of natural and expected causes. Child death cases are reviewed when the coroner has completed his or her investigation or an inquest into the death is complete. When cases are forwarded to the unit they are assigned to a case reviewer who then conducts an initial examination of the case file. The reviewer may determine additional information is required to ensure a complete understanding of the case. Once all information has been obtained, the reviewer completes a protocol that captures data on demographics, circumstances of death and risk factors. Upon completion of initial examination, cases go through an internal multidisciplinary review process. The multidisciplinary team reviews the circumstances of each case and discusses risk factors that may have contributed to the child's death. The team also determines if a death was, in all likelihood, preventable.

Once case reviews are complete, the CDRU analyzes review findings to identify areas of child death requiring targeted action or further examination. The CDRU may develop recommendations to prevent future deaths, or may recommend to the Chief Coroner that one or more child deaths be further reviewed by a child death review panel.

The purpose of a death review panel is to review the facts and circumstances of one or more deaths in order to provide advice and any recommendations to the Chief Coroner with respect to medical, legal, social welfare and other matters that may impact public health and safety in the prevention of deaths.

In cases where service delivery is determined to be a factor in the child's death, the CDRU may recommend that a case be referred to the Office of the Representative for Children and Youth. The Representative has a mandate to review the deaths of children in care or who were in receipt of services within 12 months of their death.

# Recommendation development, monitoring and implementation

In preparing for recommendation development, the unit reviews best practice for prevention and considers interventions that have shown success in other jurisdictions. Recommendations are crafted to address gaps or to advance prevention efforts already underway in the province. To facilitate this process, the CDRU identifies appropriate target agencies, assesses feasibility of suggested interventions and establishes timelines and activities involved. This helps to ensure recommendations are viable, directed appropriately and guided by evidence. Recommendations are finalized in consultation with the target agency prior to their release.

Once issued, written responses are requested from target agencies within 90 days. The unit monitors responses and subsequent follow-up activities on an on-going basis. This requires continuous collaboration with and support for the organizations tasked with implementing recommendations. Publicly reporting on follow-up activities is a means of highlighting what progress has been made towards implementation and demonstrates the commitment of target organizations in this regard. Monitoring recommendations also allows the unit to assess the positive impact the work is having on child health and safety in terms of improved policy, practice, program delivery and partnerships.

# Reporting our activities and review findings

In previous years, the Child Death Review Unit has reported out on case review findings through two types of reports; annual reports that examined child deaths referred to the unit over a one-year period, and special reports that examined child deaths resulting from similar circumstances (e.g., drowning).

In the future, there will be three types of reports. CDRU annual reports will focus on the unit's activities over that year and update progress on recommendations, as in this report; special reports will continue to examine child deaths that occurred under similar circumstances; and status reports will examine child deaths by year of death.

Analyzing cases based on year of death will increase the timeliness and rigour of the CDRU's review findings and allow for more detailed analysis of trends in child death rates and risk factors.

Reports contain detailed, non-identifying information that stakeholders can use to inform their efforts to improve child health and safety. They can be an effective tool in bringing public attention to the circumstances of child death and the factors that put children at increased risk.

# Involving family and friends

Involving family and friends of the deceased in the review process is critical to ensuring the voice of the child and family is heard and respected. As part of the review process, letters are sent to the child's primary caregiver or next of kin, which may include parents, foster parents, legal guardians or spouses. The letter informs the recipient that the death is being reviewed, and invites them to participate in the process and contact the unit with any questions.

Some caregivers contact us with questions about how their child's privacy will be protected, while others share details of their loved one's life and death. The review process is enhanced by this richer understanding of the complexities of the child's individual strengths and challenges, family dynamic and cultural or community characteristics. Family members have written letters for reports and participated as members of a death review panel. Their contributions have strengthened recommendations and impacted social policy and legislation.

# Upcoming activities

Over the next few years the CDRU will continue to engage in a number of activities to better understand how and why children die and to use those findings to take action to prevent other deaths and improve the health, safety and well-being of all children in B.C.

- We are currently in the process of conducting a five-year retrospective review of sudden and unexplained infant deaths that occurred in a sleep environment. The findings of our review will be presented in a report that will address demographics, trends, risk factors and recommendations for prevention.
- We will be conducting a review of all child deaths that occurred in 2008 and 2009. Our findings will be presented in a report that will examine trends in child death during that two-year period.
- We will be compiling and publishing the 2009 Annual Report, to foster greater awareness of our role in the prevention of child death and to highlight the work that we do.
- We will continue to strengthen our recommendation monitoring system and support the implementation of recommendations.
- We will complete reviews of any remaining child deaths that occurred prior to December 31, 2007.
- We will be enhancing our current child death data management system to facilitate more efficient data retrieval and analysis.
- We will continue to update our child death review protocol to ensure the data we capture on each child death is relevant and guided by evidence.
- We will explore new methods of identifying natural child death cases that will be of educational value to health practitioners in preventing future deaths.
- We will continue to strengthen our collaborative relationships while building new partnerships with organizations dedicated to improving child health and wellness.

# Recommendation updates

The following section provides an update on the implementation of recommendations issued by the CDRU since the enactment of the new Coroners Act in 2007.

Publicly reporting on follow-up activities is a means of highlighting what progress has been made towards implementation and demonstrates the commitment of target organizations in this regard. Monitoring recommendations also allows the unit to assess the positive impact the work is having on child health and safety in terms of improved policy, practice, program delivery and partnerships.

## Recommendation Update: 2007 Annual Report (issued July 2008)

| | Recommendation – 2007 Annual Report | Target Agency | Update |
|---|---|---|---|
| 1 | Assign demerit point penalties to the offence of failure to wear a seatbelt, to align B.C. with the majority of other provinces in Canada. | Office of the Superintendent of Motor Vehicles (OSMV) | B.C. has a number of initiatives in place to address the offence of failing to wear a seatbelt. Recent amendments to the *Motor Vehicle Act* Regulations increased the number of seatbelt-related offences and raised the fine issued for such offences to $167. Assigning demerit point penalties may also be considered as part of the OSMV's ongoing research on effective targeting of high risk drivers. |
| 2 | Change legislation and/or regulations to ensure that upon a review or intent to prohibit a young person's license in the Graduated Licensing Program, a young person's parents receive notification of that prohibition (or intent to prohibit). | OSMV | OSMV is actively investigating and considering this recommendation in collaboration with the Insurance Corporation of BC. |
| 3 | Review current policy relating to excessive speed and other high risk driving infractions to consider longer prohibitions and that a combination of these infractions would result in a review of that license by the OSMV. | OSMV | Civil forfeiture amendments were passed in Spring 2008 that allow for forfeiture of a vehicle where it is used to street race and serious bodily injury or death are likely to result. Police can request an immediate 15 day prohibition for street racing. Drivers who speed or race can receive penalty points and fines and be charged under the Criminal Code of Canada. The Superintendent can also prohibit a driver based on an unsatisfactory driving record. Additional action on this recommendation is being considered as part of OSMV's ongoing research on effective targeting of high risk drivers. |
| 4 | Review legislation to ensure that young persons who receive infractions within the Graduated Licensing Program (GLP) are unable to move to the next stage of licensing until that infraction has been adjudicated. | OSMV | OSMV continues to work with partners and monitor other jurisdictions to identify mechanisms for addressing this program concern. |

| Recommendation – 2007 Annual Report | | Target Agency | Update |
|---|---|---|---|
| **5** | Implement the DRIVE program throughout the province to help educate and inform young drivers about the risks inherent as a young driver. | Insurance Corporation of BC | ICBC completed an evaluation of the DRIVE program in Nanaimo and determined it was not suitable for province-wide expansion. ICBC will continue to provide the facilities for the Nanaimo program to educate youth. Best practices from the existing program were adapted to form the basis of a focused educational tactic targeting post-secondary youth. ICBC began piloting this educational program at Vancouver Island University in Spring 2009. |
| **6** | Achieve a higher standard of safety on pleasure craft by: a) Establishing minimum standards for Rental Boat Safety Checklists that must be used by a person who makes a houseboat or other pleasure craft available for rent. When indicated that children will be on board the vessel, standards must ensure that operators are supplied with, at minimum, child-sized Personal Floatation Devices (PFDs) and barriers to restrict child access from the vessel to the water; b) Requiring that a person who makes a houseboat or other pleasure craft available for rent provide operator training and safety orientation prior to severing their connection to the vessel. | Transport Canada | Minimum safety standards for the Rental Boat Safety Checklist are outlined in the Rental Boat Safety Checklist Standard. Small Vessel Regulations require that everyone on board a pleasure craft have a PFD or lifejacket of appropriate size. Railing height or barriers are not required on pleasure craft on the basis of impracticality. Transport Canada will continue to work with the boating industry and other stakeholders to raise awareness and change behaviour in order to prevent boating related fatalities. |
| **7** | Following assessment of possible mechanisms for the regulation of pool fencing in B.C., establish a law requiring at minimum 1.2m high, four-sided pool fencing with self-closing and self-latching gates. This standard should apply to all forms of home pools with a depth of over 0.6m and require fencing that does not facilitate climbing. | Ministry of Housing and Social Development (MHSD), Building and Safety Policy Branch (BSPB) | In October 2008, the MHSD, Building and Safety Policy Branch (BSPB) completed a scoping review of the issue and gathered relevant information in a research document, which includes an assessment of pool safety bylaws in B.C. municipalities. BSPB and the BC Coroners Service will work jointly, in collaboration with local governments and other stakeholders, to determine the most effective means of achieving a reduction in child drowning through safer pool fencing. |

| Recommendation – 2007 Annual Report | | Target Agency | Update |
|---|---|---|---|
| **8** | Develop and distribute a practical barbeque safety resource for the B.C. public, in collaboration with relevant public and private sector agencies. | Office of the Fire Commissioner | In March 2009, the Office of the Fire Commissioner, BC Safety Authority and BC Coroners Service initiated a joint project involving root cause analysis of unintentional death and injury related to the use of portable propane appliances. The goal of this project is to develop actionable strategies for prevention, which we will do by conducting and documenting the analysis of propane gas incidents, developing recommendations, and sharing lessons learned. |
| **9** | Expand the scope of the existing Safe Sleep Task Force to address infant safe sleep practices in all environments, from hospital to home, in a manner that is representational of all people and cultures across the province. | Provincial Health Officer, Ministry of Healthy Living and Sport (MHLS) | This recommendation has been referred to the Women's Healthy Living Secretariat, MHLS. In May 2009, the BC Perinatal Health Program reconstituted and expanded the former working committee for the purpose of developing guidelines for infant safe sleep. This committee is multi-disciplinary in nature and involves representation from MHLS and Aboriginal peoples. |
| **10** | Refer the case of male youth F.D. for further review of the medical treatment plan and care received at Burnaby General Hospital on May 10, 2005. | College of Physicians and Surgeons of BC | Clinical records were reviewed by the College in October 2008. |
| **11** | Refer the case of male youth F.D. for further review of the medical treatment plan and care received at Burnaby General Hospital on May 10, 2005. | Burnaby General Hospital | The Fraser Health Patient Safety Review Committee commissioned a formal review of this case. The review is complete, recommendations have been made, and an implementation process is in place. |
| **12** | Enhance the current complaint resolution and patient advocacy framework in all health authorities with a view to having a clearly defined, patient-centred and well communicated approach that is readily available to patients and their families. | Ministry of Health Services | In May/08, the *Patient Care Quality Review Board Act* received assent. The purpose of the Act is to achieve a clear, consistent, timely and transparent approach to patient complaints and concerns within each, and across all, health authorities. Patient Care Quality Offices and Patient Care Quality Review Boards have been operational since October 21/08. |

## Recommendation Update: Panel on alcohol-related deaths of Aboriginal children (Issued August 2008)

| | Recommendation – Aboriginal panel | Target Agency | Update |
|---|---|---|---|
| 1 | Consider sponsoring a project that includes:<br>• Engagement and consultation with Aboriginal youth across B.C. to seek their advice on how to increase care in community whereby no one is left on their own in a circumstance of high risk (e.g. alcohol intoxication)<br>• Use of this information to develop a risk reduction strategy that is community designed, driven and implemented in community by community;<br>• Advancing a pilot of this risk reduction strategy;<br>• Completing an evaluation of this work. | Ministry of Health Services (MHS); Ministry of Healthy Living and Sport (MHLS) | MHS and MHLS have initiated follow-up discussions with the Tripartite First Nations Health Plan management team. This recommendation will complement initiatives already underway, including development of an Aboriginal Mental Health and Addictions Framework, youth suicide prevention forums and Aboriginal ActNow initiatives. The Provincial Health Officer also recently issued a report on the impact of recent changes to alcohol policy, which provides updated recommendations to address the health and social harms from alcohol in B.C. |
| 2 | Target specific funds to provide a spectrum of alcohol prevention and treatment services for Aboriginal youth in B.C., in collaboration with Aboriginal leadership at the community level. | Ministry of Health Services | MHS and MHLS are working with the Tripartite First Nations Health Plan partners to discuss how this recommendation can be implemented in the best and most timely fashion, while coinciding with initiatives already underway. |
| 3 | Form a working group from across provincial and federal jurisdictions to explore the feasibility for supportive housing options developed specifically for Aboriginal youth in B.C. living with addiction. | MHSD, Ministry of Children and Family Development (MCFD), MHS and Health Canada | Beginning October 2008, MCFD entered discussions with MHSD and other partner ministries to explore new initiatives for supportive housing options for Aboriginal youth in B.C. living with addictions. MCFD will also be initiating discussions with its federal counterparts to determine the extent and availability of supportive housing options for youth living on reserve. Health Canada is prepared to work in partnership with B.C. First Nations and appropriate provincial bodies to find meaningful and timely solutions for Aboriginal youth in need, and is committed to addressing these issues in a culturally sensitive, respectful and competent manner. |

| | Recommendation – Aboriginal panel | Target Agency | Update |
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| **4** | In collaboration with MCFD, oversee the development of a community designed and delivered protocol intended to guide communities in cross-jurisdictional responses when critical issues related to child wellness arise (suicide; multiple child deaths in motor vehicle crash). | Provincial Advisory Committee on First Nations Health (PACFNH) | This recommendation will be tabled at the next PACFNH meeting, scheduled for June 2009. MCFD is prepared to work with PACFNH in a collaborative partnership to support community engagement in developing resources that support cross-jurisdictional responses to critical issues related to child wellness. |
| **5** | Ensure BC Coroners Service policies reflect an expectation of culturally sensitive practice, including:<br>• human resources and investigative policies;<br>• basic training that addresses cultural awareness and sensitivity (either through direct instruction, self-study or on-line learning)<br>• support for Coroners to strengthen working relationships and liaisons with Aboriginal leadership within their communities. | BC Coroners Service | A review of BC Coroners Service policy is in progress. Training plan enhancements will take place in conjunction with new government-wide initiatives. The BC Coroners Service remains committed to building stronger collaborative relationships with Aboriginal leadership, communities and peoples. |

## Recommendation Update - Panel on child and youth suicide (Issued December 2008)

| | Recommendation – Suicide Panel | Target Agency | Update |
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| 1 | As government develops an updated 10-year mental health plan for B.C.: a) adopt a government wide approach to promotion, prevention and early intervention in mental health for children and youth, including detection and response to suicidal behaviour, similar to the province's approach to the promotion of positive physical health; b) call for targeted efforts to reduce the stigma and discrimination associated with mental disorders. | MHLS, MHS, Provincial Health Services Authority (PHSA) | MHS, MHLS, MCFD and MEd are working together to develop a comprehensive and unified plan to address the panel's recommendations to government, in the context of new and renewed initiatives to address child and youth mental health generally and suicide, specifically. MHS and MHLS continue to lead the development of the 10-Year Plan to Address Mental Health and Substance Use in BC; this recommendation coincides with proposed strategic directions of the plan, including promoting positive mental health, preventing mental illness, and addressing stigma and discrimination. There are also initiatives underway that already address aspects of this recommendation, including the Provincial Strategy to Improve Health Literacy in Mental Health and Addiction. Led by the PHSA, this strategy supports the implementation of an integrated, best practice framework to improve public understanding of mental health and addictions. |
| 2 | Develop population-level mental health indicators to support effective delivery of population mental health strategies and enhanced knowledge of the mental health status of B.C. children and youth. | MHLS | In February 2009, MHLS, in collaboration with B.C.'s six health authorities, completed development of model core public health programs in the areas of promoting mental health; preventing mental disorders; and preventing harms associated with substance use. MHLS is also working with Statistics Canada, the Public Health Agency of Canada and other partners to explore the feasibility of adapting existing validated and reliable survey instruments to measure population level positive mental health at provincial, regional and local levels. |

| | Recommendation – Suicide Panel | Target Agency | Update |
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| **3** | To increase resiliency and coping skills in children and youth, deliver curriculum-based universal skill-building programs in all B.C. schools. | MEd, BC School Trustees Association | MEd is working with the MHS, MHLS and MCFD to develop a coordinated plan to address this and other panel recommendations directed to their ministries. The BCSTA supports the recommendations and is interested in working toward their implementation in collaboration with MEd and other partners. The MEd and other ministries are also involved in supporting the provincial Suicide Prevention Intervention & Postvention Initiative (led by the Crisis Intervention and Suicide Prevention Centre), which includes the development of a provincial framework to guide local, regional and provincial efforts to address suicide prevention, intervention and postvention across the lifespan. |
| **4** | Develop a mental health literacy tool to assist B.C. families in recognizing and responding to signs of mental health problems involving children and youth, and to distinguish these from normal developmental processes. | MCFD | MCFD continues to work with key stakeholders on child and youth suicide prevention and will be addressing this recommendation as part of a unified response being put together by partner ministries. In addition to collaborating on the development of the 10-year mental health plan, MCFD commissioned a review of the five-year Child and Youth Mental Health Plan and is now engaged with partner ministries to address the review's recommendations (available at mcf.gov.bc.ca). MCFD has also consulted on the development of B.C.'s Provincial Strategy to Improve Health Literacy in Mental Health and Addiction. |
| **5** | Establish a web-based information clearinghouse that will serve as a centralized access point for resources on promotion, prevention and early intervention in mental health (including suicide prevention and postvention). Its development should include a communications plan that promotes use by both professionals and the public. | MCFD, MHLS | In 2008, MCFD coordinated suicide prevention, intervention and postvention best practice material for service providers on their Child & Youth Mental Health website. MCFD and MHLS are considering further action in support of this recommendation, in collaboration with partner ministries and in the context of existing initiatives already underway. |

| | Recommendation – Suicide Panel | Target Agency | Update |
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| **6** | Across B.C., deliver community-based gatekeeper training programs to improve recognition of and response to suicidal behaviour among those who have regular, non-clinical contact with children and youth. Programs should include an evaluation component and target a diverse group of potential interveners in the community - for example, teachers, coaches, employers, police officers, probation officers, clergy and other community leaders. | Crisis Intervention and Suicide Prevention Centre of B.C. | The Crisis Centre put forth a proposal for the initiation of a joint project to address this recommendation. In the interim, the Centre is evolving its school-based youth suicide prevention program into a comprehensive gatekeeper program, targeting both peers and adults. The Centre has also implemented seminars for school personnel and counseling staff and is piloting a new workshop for parents; an evaluation of this workshop will be available in the summer of 2009. |
| **7** | Offer evidence-based peer recognition and response training to youth in all B.C. school districts. This training should be offered on a continual basis and be delivered as part of a holistic school-based approach to preventing suicide that incorporates other recommendations made by the panel, including universal systematic screening and the development of crisis response protocols. | MEd, MCFD, BCSTA, Crisis Intervention and Suicide Prevention Centre of B.C. | This recommendation will be addressed as part of the unified response plan being developed by relevant ministries and their partners. The Crisis Centre is well positioned to work with these ministries and other key stakeholders on offering peer recognition and response training to youth. For the past 18 months, the Crisis Centre has delivered a new classroom workshop based around its innovative film, *Choices2: Reaching Out*, to more than 200 classrooms in the Lower Mainland. A four-module school workshop series is also being piloted in Vancouver in collaboration with the University of Victoria. |
| **8** | To improve school connectedness, engagement and attendance among B.C. youth, implement systematic, school-based screening to identify students who require enhanced skills-based social support. This screening program should incorporate evidence-based suicide predictors and include measures to ensure that enhanced support and adequate follow-up are provided when a need is identified. | MEd, MHLS, BCSTA | This recommendation aligns with proposed strategic directions of the 10-year Plan to Address Mental Health and Substance Use in B.C., which includes identification, early intervention and support of people and communities to address mental health and substance use problems. Further implementation of this recommendation will be undertaken collaboratively by MEd, MHLS, MHS, MCFD and BCSTA in the context of the 10-year Plan and other relevant initiatives already underway. |

| | Recommendation – Suicide Panel | Target Agency | Update |
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| 9 | Using a determinants of health approach to address emotional and behavioural problems among children and youth, implement provide-wide policies or programs that aim to improve school connectedness. Interventions should integrate both school-based and community-based strategies to improve a child or youth's connection with peers, teachers and the learning process. | MEd, MHLS, BCSTA | This recommendation is congruent with existing collaborative efforts of MEd and MHLS, and will guide future developments aimed at preventing child and youth suicide. Policies and programs to improve school connectedness correspond to the 10-year plan's proposed emphasis on promoting positive mental health and wellness from a whole systems perspective, which promotes integration across sectors and collaboration with local governments and communities. |
| 10 | Improve means restriction efforts in B.C. by: a) retrofitting the five bridges in B.C. that are responsible for over 50 per cent of suicide deaths by jumping from 1991 to 2007 (Burrard St. Bridge, Granville St. Bridge, Iron Workers Memorial Bridge, Lions Gate Bridge, Patullo Bridge) with barriers to prevent future suicide deaths by jumping; b) developing policy that establishes criteria for determining when bridges should be outfitted with barriers to prevent suicide by jumping, and enforcing this policy in the construction of all new bridges in B.C. | Ministry of Transportation and Infrastructure (MTI) | MTI has retained a consultant to investigate potential suicide prevention measures on the Lions Gate and Ironworkers Memorial bridges. MTI will carefully analyze the findings to determine the feasibility of identified measures and form the groundwork for future policy. MTI has also worked with the Crisis Centre, Vancouver PD and Telus to install crisis hotline phones on the Lions Gate Bridge. The Granville St. and Burrard St. bridges fall under the City of Vancouver's jurisdiction. The Patullo Bridge is the responsibility of TransLink. This recommendation has been shared with the above agencies and is now under their consideration. |
| 11 | Develop and distribute a policy handbook to support accurate, consistent interpretation and practice of confidentiality requirements among those working in child-serving jurisdictions. This handbook should address appropriate sharing of information within the circle of care, including families, when a child or youth is determined to be at risk to him/her or others, as dictated under relevant provincial and federal legislation. | Information and Privacy Commissioner (IPC) | The IPC supports the development of a policy handbook to ensure consistent interpretation and application of privacy law to sharing of personal information within the circle of care where a child or youth is determined to be at risk to him/her or others. However, preparation of such a document requires the expertise of those who have a thorough understanding of child welfare, and relevant information flows, and also requires further resources. The future direction of this recommendation is under consideration by CDRU. |

| | Recommendation – Suicide Panel | Target Agency | Update |
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| **12** | Provide point-of-care practitioners across B.C. with ongoing yearly continuing professional education on effective recognition and treatment of adolescent depression and suicidal behaviour. | MCFD, MHS, BCMA, College of Registered Nurses of BC (CRNBC), BC School Counselor's Association (BCSCA) | Through a contract with the Justice Institute, MHS and MCFD have developed the Youth Concurrent Disorders on-line education for practitioners in Child and Youth Mental Health and Youth Addictions. Targeting child and youth mental health and youth addiction practitioners, the curriculum will include training on youth suicide screening, risk assessment, response and safety planning, and provide general information about the prevalence, research and risks for suicide. In partnership with the BCMA, MHS is also pursuing a project focused on the development and implementation of training for primary care physicians on mental health and substance use. The BCMA is currently developing a policy paper on the issue of depression that it will release later this year and encourages efforts around physician education to be coordinated with the appropriate CME or other bodies as appropriate. As key frontline personnel, the BCSCA also supports this recommendation and renews its commitment to being an active participant in developing and delivering province wide initiatives. |
| **13** | Develop a suicide response protocol for B.C. hospital emergency rooms, to be initiated after an assessment of a child or youth in an emergency ward when suicidal behaviour has been noted. The protocol should specify that at the point of discharge from the ER, the following occurs: a) notification of parent/guardian; b) education of family/caregivers on restricting access to suicidal means within the home; c) creation of safety plan; d) immediate notification of the patient's community mental health team; e) sending of a discharge summary to the patient and family, the patient's family doctor and community mental health team. Upon receiving notification, the community mental health team should follow up with the child/youth within 24 hrs. | MHS, MCFD | The proposed suicide response protocol is consistent with the current standard of practice within the Child and Adolescent Mental Health and Addiction Program for children and youth assessed in the BC Children's Hospital Emergency Room. Other planned initiatives include the development of a suicide assessment protocol for use in emergency departments and primary care clinics. Child Health BC, a network of the province's five health authorities, PHSA, health professionals and health care facilities will take a facilitating role in the development of this protocol in collaboration with MHS and MCFD. BC Mental Health and Addiction Services and BC Children's Hospital are also developing a Dialectical Behavioural Therapy program specifically designed to treat chronically suicidal youth. In addition to treatment and research, the program will facilitate improved linkages between B.C. hospital emergency rooms and outpatient programs to support effective discharge planning. |

| | Recommendation – Suicide Panel | Target Agency | Update |
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| **14** | Establish a provincial task-force that will advance suicide postvention efforts in B.C. by completing an environmental scan of crisis-response teams and/or suicide-response protocols that exist in B.C. municipalities, and: a) where response teams exist, determining their nature and membership, and b) in municipalities that currently lack them, supporting the establishment of crisis-response teams or protocols while encouraging the use of existing postvention models that have shown success in other jurisdictions. | PSSG, MEd, MCFD, MHS, MHLS, Crisis Intervention and Suicide Postvention Centre of B.C., First Nations Health Council | The Crisis Centre suggests that follow-up to this recommendation coincide with the existing Suicide Prevention, Intervention and Postvention (PIP) Initiative, which includes representation from health authorities, MEd, PSSG, MCFD, MHS and MHLS. The PIP executive committee is currently completing an inventory of suicide services across the province. In addition, the First Nations Health Council is working with First Nations to develop/advance community-based efforts for crisis-response teams and suicide-response protocols, and is planning for the development of an overall provincial strategy for First Nations mental wellness. Target agencies will be working together to assess how to best implement this recommendation, in the context of these and other relevant activities already underway. |
| **15** | As supported by the provincial *Public Health Act*, develop a surveillance system for suicide attempts in B.C. that brings together currently available data systems and draws from successful surveillance models in other areas. | MHS, MHLS | The Provincial Health Officer (PHO) will explore with staff from the acute care and mental health systems whether or not any current systems are capable of capturing information in a timely, consistent and comprehensive manner, and whether a regulation under the new Public Health Act, requiring suicide attempts to be reportable by health practitioners, would be likely to achieve the desired end. The PHO will also ask that the international literature be reviewed to determine whether other jurisdictions have developed systems that could be modified or recommended for B.C. |
| **16** | Adopt and ensure province-wide adherence to best practices for media coverage of suicide deaths, as outlined in currently available guidelines, such as the (US) Centres for Disease Control and Prevention's Reporting on Suicide: Recommendations for the Media. | B.C. Press Council; Canadian Association of Broadcasters (CAB) | At the provincial level, the B.C. Press Council advised that there is an unwritten standard to which responsible newspapers adhere when covering suicides. The Council has reaffirmed best practices for suicide reporting with its 123 member newspapers. At the federal level, this recommendation has been redirected from CAB to the Radio-Television News Directors Association (RTNDA) Canada. While the RTNDA Code does not specifically address the issue of child suicide, there is a provision regarding the need for broadcast journalists to use "special sensitivity when dealing with children." This recommendation will be brought to the RTNDA board in June for discussion on whether additional measures might be appropriate for ensuring best practices among electronic journalists in Canada. |

| | Recommendation – Suicide Panel | Target Agency | Update |
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| 17 | Following a suicide death, ensure that survivors receive existing postvention resources directly. Suicide survivors may include family members, friends, school peers, care providers, co-workers and others who have been affected by a suicide death. | Ministry of Public Safety and Solicitor General (PSSG) | PSSG will work with relevant ministries in examining resources currently in place and how to enhance delivery of services for suicide survivors, including family members, friends, peers, co-workers and others. |

## Recommendation update – 2006 Annual Report (Issued December 2007)

| | Recommendation – 2006 Annual Report | Target Agency | Update |
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| 1 | Move beyond the review of best practice guidelines for the use of off-road vehicles towards a regulatory framework on licensing and registration of off-road vehicles. | Ministry of Tourism, Culture and the Arts | Government continues to explore a regulatory framework around the management of off-road vehicles (ORVs) on provincial Crown land. A new ORV framework will require six months to a year to complete and is expected to focus on safety and registration. |
| 2 | Examine the viability of linking licensing of specific motorcycles to specific training and education. | Chief Coroner of BC; Office of the Superintendent of Motor Vehicles | As part of the broader Motorcycle Safety Project, the Insurance Corporation of British Columbia is undertaking an analysis of potential changes to BC's motorcycle licensing program. |
| 3 | Provide specific findings related to exposure deaths of Aboriginal children to the Representative for Children and Youth (RCY), to inform advocacy strategies for Aboriginal communities in BC. | Chief Coroner of BC | Investigative findings related to exposure deaths of Aboriginal children were provided to the RCY in December 2007. A member of the RCY advocate team also participated in the child death panel that examined alcohol-related death of Aboriginal children, held in Spring 2008. |
| 4 | All law enforcement jurisdictions review current policy to ensure the inclusion of actions required when attending a scene where the victim may be hypothermic. | BC Association of Chiefs of Police | RCMP and municipal police agencies have been instructed to review their policies as recommended. The Police Services Division of PSSG will support independent municipal police requiring assistance with policy development on this issue. |

| Recommendations – 2006 Annual Report | | Target Agency | Update |
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| **5** | Provide survivors of suicide with a practical guide for dealing with a suicide death, using best practice resources that are currently available in the province. | Chief Coroner of BC | Regional Coroners have been advised that the resource *'Hope and Healing – A Practical Guide for Survivors of Suicide'* is readily available for Coroners to utilize. Timing and appropriateness of distribution by the investigating Coroner must remain a decision between Coroner and his or her supervisor. |
| **6** | School districts review policies related to suicide risk assessments to ensure they include the identification and assessment of any acute crises presenting in the child's life. | Ministry of Education (MEd) | In February 2008, MEd instructed School District Superintendents to review policies and practices in their district. In addition, MEd and the MCFD have made a joint effort to make suicide prevention information available to school districts to inform the review of policies and practices. |
| **7** | Initiate regulations that require mandatory trigger locks for all firearms at the time of purchase, and further, that written safe storage guidelines also be provided at point of sale. | Canadian Firearms Centre (CAFC) | The *Firearms Act* includes many requirements that are safety-oriented. Safe storage, which is one of these requirements, states that all firearms must be stored unloaded and be made inoperable, usually through a locking device. Changes to the Act or associated regulations now fall under the purview of the Minister of Public Safety Canada. |
| **8** | Require that written reports pertaining to child deaths classified as undetermined be reviewed by the child death investigation and paediatric investigation coroners prior to conclusion. | Chief Coroner of BC | Case work is now examined and measured against an established set of criteria, including policies related to the classification of undetermined child deaths. |
| **9** | Establish a Child Death Review Panel to review alcohol-related deaths of Aboriginal children and youths in B.C. | Chief Coroner of BC | In April 2008, the Chief Coroner convened panel under section 49 of the *Coroners Act* to examine the lives and deaths of six Aboriginal children where alcohol and/or substance use was determined to be a contributory factor in their deaths. The Panel's final report to the Chief Coroner included five recommendations for the prevention of similar deaths in the future. |
| **10** | In all sudden unexpected deaths of infants, complete detailed death scene investigations and scene re-creations, conducted by coroners who have received specific training in these areas. | Chief Coroner of BC | The distinction between sudden infant death terminology and the benefits and use of scene recreation were emphasized during the child death investigation presentation given during 2008 BCCS Basic Training. Terminology and sleep-related risk factors for infants were also included in final exam questions. |

# How to reach us

For more information or to be added to our distribution list, contact the Child Death Review Unit:

BC Coroners Service
800 – 4720 Kingsway
Burnaby, BC
V5H 4N2

Tel: 604.660.7745
Fax: 604.660.7766
Email: BC.CorSer@gov.bc.ca

Child Death Review Unit reports are available online at:
www.pssg.gov.bc.ca/coroners/child-death-review/index.htm