

BACKGROUND

For Immediate Release
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British Columbia Coroners Service
Ministry of Public Safety
and Solicitor General

CHILD DEATH REVIEW UNIT

The Child Death Review Unit (CDR Unit) of the BC Coroners Service is committed to a comprehensive review of child deaths 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 British Columbia.

RESULTS OF AGGREGATE REPORTING

This report is a summary of 640 child deaths that were reviewed by the CDR Unit between January 2003 and January 2006. Of these 640 deaths, 286 were Coroner cases and 354 (55 per cent) were Natural, expected deaths (reported to the Coroners Service by BC Vital Statistics Agency) or Non-Coroner cases. The remaining 45 per cent of deaths were sudden and unexpected. All Coroners cases reviewed in this report were investigated by the BCCS and reviewed by the CDR Unit.

For all sudden and unexpected deaths, accidents were the most common manner of death and accounted for 52 per cent of reviewed Coroner cases.

Manner of Death	Number (%) of Coroner cases
Accident	148 (52%)
Natural	55 (19%)
Undetermined	38 (13%)
Suicide	36 (13%)
Homicide	9 (3%)
Total	286

ADDITIONAL FINDINGS FROM THE ANALYSIS

- Fatalities were most common in children younger than one year or 15 years of age or older.
- The number of deaths of male children was almost twice that of female children. This trend was observed for all manners of death, except Natural deaths.
- Excessive speed and lack of restraint were contributing factors more commonly reported in single, rather than multiple, vehicle accidents.
- Aboriginal children were over-represented in the deaths of children in the care of or receiving services for the Ministry of Children and Family Development.
- Risk factors were identified and known in 44 per cent of the children who committed suicide. These factors include expressed suicidal thought in verbal, written or electronic format, and family and relationship discord.

CHILD DEATH REVIEW UNIT RECOMMENDATIONS

The CDR Unit will be working with various agencies to strengthen relationships, address the above recommendations and develop additional recommendations. The actions and responses to these recommendations will be followed by the CDR Unit and discussed in future reports.

It is recommended that:

1. children should always be placed in an approved car seat and/or restrained with a seatbelt when travelling in a motor vehicle;
2. all levels of government, educators, parents, and Aboriginal leaders and their communities forge new relationships led by the Aboriginal people to address the results of this report that clearly illustrate that Aboriginal children are dying at disproportionately higher rates;
3. children should know and be taught how to swim when playing in and around water. It is also recommended that younger children are supervised playing in and around natural bodies of water, pools or bathtubs;
4. parents and caregivers should know and use safe sleeping practices with infants under one year of age;
5. firearms and ammunition should always be safely stored and inaccessible to children;
6. the Chief Coroner direct the BCCS to evaluate whether any disparity exists between the number of recommendations made in cases of Aboriginal child deaths and non-Aboriginal deaths; and
7. all sectors of Government and communities, including the youth and teenage community throughout B.C., establish dialogue and strategies for the prevention of suicide.

DEFINITIONS

In the report, data from the reviewed child deaths are presented by the 'manner of death' of the child. The manner of death is the event or situation which ultimately led to the death, but is not the underlying cause of death. The manner of death is assigned by the Coroner at the completion of the investigation for each death. The five categories of manner of death are Accident, Homicide, Suicide, Natural and Undetermined and are defined below:

Accident: Death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.

Homicide: Death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.

Natural: Death primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.

Suicide: Death resulting from self-inflicted injury, with intent to cause death.

Undetermined: Death which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as Natural, Accidental, Suicide or Homicide.

Coroner Case: A mandated investigation of a sudden and unexpected death to determine the identity and where, when, how and by what means the death occurred.

Non-Coroner Case: Where the scene, body and circumstances or history are consistent with a known natural disease process and do not fall under the mandate for a full Coroners Investigation under Section 9 of the Coroners Act. In all non-Coroner cases, the death certificate is signed by a physician.

Natural Expected Death: A person who dies from a natural disease process while under the care of a physician. Natural expected deaths are not required to be reported to the Coroners Service.