



CHILD DEATH INVESTIGATIONS and REVIEWS

The death of a child is a great loss to family, friends and the community. Understanding the circumstances surrounding a child's death is one way to help make sense of the tragedy and may help prevent deaths of other children. This information is to help you understand how and when the Coroners Service becomes involved when a child dies in British Columbia. It also explains the difference between child death investigations and child death reviews.

CHILD DEATH INVESTIGATIONS

Whenever a child dies, the BC Coroners Service is responsible for determining the child's identity and how, when, where and by what means he or she died. This is done through a Coroner's investigation. During the investigation, a specific child death investigation protocol is followed to ensure that this process is thorough and consistent.

Children are not small adults. Their bodies are structurally different and constantly in a state of change as they develop over time. Child death must always be treated with that in mind. For example, automatic reflexes are not developed in infants. If while sleeping, an infant moves into an unsafe sleeping position that compromises its airway, the infant's automatic reflexes will not cause the child to shift positions as an adult's would. Coroners specially trained in child death investigation may assist the local Coroner with an investigation. These Coroners are trained to understand the unique aspects of dealing with child death and to ensure that information gathered is considered from a paediatric perspective.

When a child death is reported to the Coroner, he/she has the authority to collect information through interviews, documents and records and through what is observed and collected at the scene of the death. The Coroner is also responsible for authorizing any tests or examinations. In many cases of unexpected deaths of children under 3-years-old, an autopsy will be performed. This can be difficult for families. It is important for you to know that these cases are handled with sensitivity and great care.

Sometimes a case will proceed to an inquest; this is decided on a case-by-case basis. An inquest is a formal court proceeding where a five-person jury hears evidence relating to a death. The presiding Coroner ensures that the jury maintains its goal of fact-finding not fault-finding.

At the end of an investigation or inquest the cause and manner of death are determined. In both cases, this information together with any recommendations to prevent future deaths is provided to the family in a written report.

CHILD DEATH REVIEWS

All child death cases are referred to the Child Death Review Unit (CDRU). The intent of the review is to understand who the child was in life and to learn about the factors that may have contributed to death. CDRU reviews every child death in the province, including those children who die from pre-diagnosed natural disease processes, where the death is expected. CDRU completes a more comprehensive examination of all aspects of the child's life and death. Reviews may be done on individual cases or groups of cases together.

Parents, caregivers and family members are most often involved in the Coroner's investigation into the death of their loved one. This normally happens at the time the death is reported. The CDRU may ask for the same involvement at the time the child's death is reviewed, which happens after the investigation has been completed. This normally happens about a year later. Investigations of unexpected deaths usually take more time to conclude than those for natural expected deaths, therefore reviews following natural expected deaths may occur sooner.

The CDRU is staffed with a team of multi-disciplined specialists who will complete a comprehensive review focused on prevention and increased public awareness of the issues that affect the health and well-being of all children. The review process is based on a public health model with reviews conducted individually or as part of a group. In some cases, as part of the review process, child deaths will be examined by an external multi-disciplinary panel of experts who may make additional recommendations.

Parents or family members may be contacted by members of the CDRU to assist the CDRU in the review process. The lessons learned will be shared and used to develop risk reduction prevention strategies so that similar deaths do not occur.

HELP IS AVAILABLE

Coroners can be contacted by phone, at no charge, through Enquiry BC:

- Vancouver, 604 660-2421

- Victoria, 250 387-6121

- Toll-free, 1 800 663-7867

(ask the Enquiry BC operator to transfer your call to 604 660-7745)

B.C. Bereavement Helpline:

Provides assistance to people who are dealing with the loss of a loved one.

- Vancouver, 604 738-9950

- Toll-free, 1 877 779-2223

Website: www.bcbereavementhelpline.com

VictimLINK:

A multi-lingual, 24-hour helpline that can connect callers to a network of resources, including police and community-based victim services, throughout B.C. You can check out the Victim Services Directory online at: www.pssg.gov.bc.ca/victim_services or call VictimLink, toll-free: 1 800 563-0808