
NEWS RELEASE

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Ministry of Public Safety and Solicitor General
Coroners Service

ANNUAL REPORT PROBES CAUSES OF CHILD DEATH

BURNABY – While motor vehicle incidents remain the main reason why B.C. children die accidentally, for the first time, suicide is now the second leading cause of preventable death, according to annual report data released today by the Child Death Review Unit (CDRU) of the BC Coroners Service.

Another key finding of the report is that the majority of child deaths (74 per cent) were natural and expected and most involved children less than one year of age who died of difficulties in the perinatal stage of life. The CDRU reviewed 244 child deaths from across the province between 2003 and 2006 in their latest annual report.

“Children in B.C. continue to die in motor vehicle incidents in staggering numbers,” said Kellie Kilpatrick, director of the CDRU. “These findings support the need for us to continue our collective efforts to find innovative ways of reaching out to youths and their families. At the same time, the increase in suicides is an obvious concern, and we will be conducting a separate review of suicide deaths referred to the CDRU over the past five years to try to find some answers.”

Key findings from the 244 cases reviewed in the report include:

- Accidental death was three to four times more frequent for males than females.
- Vehicular incidents accounted for the highest number of accidental deaths, of which unsafe speed was the leading risk factor.
- Suicide was the second leading cause of preventable death and the majority of children who died by suicide had stated their intent prior to their death.
- In cases of Sudden Unexpected Death in Infancy (SUDI), medical and developmental vulnerability combined with exposure to an unsafe sleep environment was noted.
- Aboriginal children were over represented among cases of sudden and unexpected death. Alcohol was a risk factor in the majority of fatal injuries involving Aboriginal children.
- Children in care of the Ministry of Children and Family Development were not over represented in the report.

The report examines trends and patterns found in the 244 deaths. Contributory risk factors in sudden and unexpected deaths included youth driving with multiple passengers, alcohol and substance use and, for younger children, unsafe sleep practices.

There are 10 recommendations to various agencies. Recommendations include examining the viability of linking licensing of specific motorcycles to specific training and education; and initiation of regulations requiring mandatory trigger locks for firearms at time of sale.

The CDRU Annual Report 2006 is available online at:
www.pssg.gov.bc.ca/coroners/child-death-review/index.htm

The Child Death Review Unit of the BC Coroners Service is committed to a comprehensive review of all 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.

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