



Child Health Standards Committee

2016 Mortality Review



Acknowledgements

The Child Health Standards Committee (CHSC) wishes to acknowledge the continuing support of the following organizations. The information they provide has assisted the CHSC in its deliberations.

- Office of The Chief Medical Examiner
- Health Information Services, Manitoba Hospitals
- Manitoba Vital Statistics
- First Nations and Inuit Health Branch, Health Canada
- Insurance Division, Manitoba Health
- IMPACT/WRHA injury prevention program

The CHSC acknowledges the interest and cooperation of physicians and health care facilities across the province in providing information for the review process.

Due to the extensive and complex nature of these reviews, which rely on completed reviews from other standards committees, and the need to obtain documentation from numerous points of contact in the healthcare system, the CHSC annual mortality review reports are typically published several years after the date of death. This report summarizes deaths which occurred in 2016.

The committee is grateful to Manitoba Health for providing financial support.

Executive Summary 2016

- The Child Health Standards Committee (CHSC) reviewed 96 deaths which occurred in 2016. 67 were children 29 days to 14 years of age, 24 were teens 15 to 17 years of age, one was an infant less than 29 days of age and 4 were children whose place of residence was out of province.
- The mortality rate for Manitoba children aged 29 days to 14 years was 26.6 per 100,000 in 2016 compared to 27.8 per 100,000 in 2015 and 26.5 per 100,000 in 2014. The mortality rate for Manitoba teens 15 to 17 years of age was 47.6 per 100,000 in 2016 compared to 33.7 per 100,000 in 2015 and 27.8 per 100,000 in 2014.
- The infant mortality rate was 5.7 per 1,000 live births, which is similar to 2015, when it was 5.9 per 1,000 live births.
- The cause of death was classified as preventable for 24 of the 67 child deaths (36%) and 22 of the 24 teen deaths (92%). Injury (unintentional injury, suicide, homicide) accounted for all of the preventable deaths apart from one sudden infant death in an unsafe sleep environment.
- Injury was the leading cause of death overall, accounting for 30% of deaths among children and 92% of deaths among teens. In children 29 days to 14 years of age, the most common causes of injury-related mortality were suicide, drowning, and motor vehicle collisions. The most common cause of injury-related mortality in teens was suicide and motor vehicle collisions.
- There were 14 suicides in 2016, compared to 14 in 2015 and 10 in 2014. In 2016, nine suicides were teens 15 to 17 years of age and five were 14 years of age or younger.
- The CHSC initiated educational action with seven physicians with respect to medical care provided. Seven referrals were made to health administrators, professional bodies, other organizations or government departments. The committee reviewed additional actions taken by other standards committees.

Table of Contents

	INDEX OF FIGURES AND TABLES	5
	DEFINITIONS	6
➤ PART 1:	INTRODUCTION	7
	• Background	
	• Goals and Objectives	
➤ PART 2:	COMMITTEE ACTIVITIES	8
	• Child Health Issues	
	• Clinical Guidelines and Newsletter Items	
➤ PART 3:	STATISTICAL SUMMARY	9
	• Mortality Rates	9
	▪ Deaths Grouped by Age for Manitoba Residents	
	▪ Deaths Grouped by Sex for Manitoba Residents	
	▪ Infant Mortality Rates	
	▪ Regional Mortality Rates	
	• Causes of Childhood Death	14
	▪ Sudden Infant Death	
	▪ Deaths from Injury	
	▪ Autopsies	
➤ PART 4:	TEEN DEATHS, 15 TO 17 YEARS	22
➤ PART 5:	PREVENTABILITY OF DEATH	25
	• Childhood Deaths	
	• Teen Deaths	
	• Educational and Other Actions	
➤ PART 6:	RECOMMENDATIONS	27
	CHILD HEALTH STANDARDS COMMITTEE MEMBERSHIP	28

Index of Figures and Tables

FIGURES

Figure 1:	Mortality Rates (Children 29 days to 14 years)	9
Figure 2:	Infant Mortality Rates	11
Figure 3:	Sudden Infant Death (Children < 1 year)	16
Figure 4:	Mortality Rates from Injury (Children 29 days to 14 years)	17
Figure 5:	Mortality Rates from Injury By Age Group (Children 29 days to 14 years)	18
Figure 6:	Suicide among Children 14 Years of Age and Younger	19
Figure 7:	Mortality Rates in Teens (Teens 15 to 17 years).....	22
Figure 8:	Deaths by Cause in Teens (Injury vs. Natural Causes)	23

TABLES

Table 1:	Mortality Rates by Age Group	10
Table 2:	Mortality Rates by Sex	10
Table 3:	Infant Mortality Rates by Province and Territory	12
Table 4:	Regional Mortality Rates (Children 29 days to 14 years)	13
Table 5:	Causes of Death (Children 29 days to 14 years)	14
Table 6:	Causes of Post-Neonatal Infant Death (Children 29 days to 14 years)	15
Table 7:	Injury-Related Mortality Rates by Age Group	20
Table 8:	Types of Injury Causing Death (Children 29 days to 14 Years)	20
Table 9:	Causes of Death (Teens 15 to 17 years)	24
Table 10:	Types of Injury Causing Death (Teens 15 to 17 years)	24
Table 11:	Educational Actions.....	27

Definitions

Age-Standardized Rates: Death rates are adjusted to account for the differing proportions of children by age group in different regions. Because infants are more likely to die than older children, a region with a higher proportion of infants would have an inflated death rate unless adjustments are made.

Delayed Neonatal Death: The death of an infant occurring after 28 days of age, who under natural selection circumstances, without the benefit of neonatal intensive care, would have died before 28 days of age.

Mortality Rate: The number of deaths occurring in a specified population per 100,000 population per year. Mortality rates for children under five years of age are usually reported as deaths per 1,000 population or 1,000 live births.

Infant Mortality Rate: The number of deaths occurring prior to one year of age per 1,000 live births.

Neonatal Mortality Rate: The number of neonatal deaths per 1,000 live births.

- **Early:** before the 7th full day of life (<168 hours), or
- **Late:** between the 8th and 28th full day of life (≥168 hours to <672 hours)

Post-Neonatal Mortality Rate: The number of deaths from 29 days to one year of age per 1,000 live births.

Sudden infant death syndrome (SIDS): infant deaths that cannot be explained after a thorough case investigation, including a scene investigation, autopsy, and review of the clinical history.

Sudden unexpected infant death (SUID): a sudden and unexpected death, whether explained or unexplained (including SIDS), occurring during infancy.

Under Five Mortality Rate: The number of deaths occurring prior to five years of age per 1,000 population.

Three-Year Moving Average: Three-year moving averages are used in some of the calculations because large fluctuations in rates may occur from year to year in small populations such as Manitoba. This rate is calculated by averaging the rate for 3 one-year periods and presenting that rate using the median year. For example, data for 1999, 2000, and 2001 rates are averaged and presented as a “2000” rate.

1. Introduction

Background

In 1976, The College of Physicians and Surgeons of Manitoba established the Paediatric Death Review Committee. In 2001, this committee was renamed the Child Health Standards Committee. This committee reports to the Central Standards Committee of the College of Physicians & Surgeons of Manitoba. The major function of all Standards Committees is to maintain and improve quality of care through education. ***These educational functions of the College are separate and distinct from its disciplinary functions.***

Educational strategies used by the Child Health Standards Committee include:

- Sending letters to physicians, hospitals, Area Standards Committees and regulatory agencies for other health professionals.
- Publishing articles in the College Newsletters to draw members' attention to important aspects of medical care involving children.
- Developing and disseminating recommendations to improve paediatric care.
- Advocating for the health of Manitoba children by informing government and other public agencies of recommendations to improve legislation or public policy.

Goals and Objectives

To monitor and improve the quality of medical care provided to Manitoba children by:

- Reviewing all deaths in the province of children between the ages of 29 days and the day before their 18th birthday.
- Determining whether or not each death was preventable at the family, community or medical care level.
- Communicating with involved practitioners or agencies where medical care or other actions could have affected the outcome.
- Making recommendations to government, medical organizations and the community at large regarding preventable mortality and morbidity.

2. *Committee Activities*

In addition to reviewing deaths, the Child Health Standards Committee functions as a sounding board for child health issues for the College of Physicians & Surgeons of Manitoba.

The Medical Consultant conducts the initial case reviews and, with the administrative assistant, sends out and receives correspondence, maintains the database, contributes to the development of draft Newsletter items, attends relevant meetings and collaborates with other interested parties.

Regional mortality rates are reported using the boundaries of the Manitoba Regional Health Authorities (RHAs). On June 1, 2012, the previous 11 RHAs were amalgamated into five larger regions. The new RHAs are listed below, with the old RHAs listed in brackets:

- Winnipeg (Winnipeg, Churchill)
- Interlake-Eastern (Interlake, North Eastman)
- Prairie Mountain (Assiniboine, Brandon, Parkland)
- Southern (Central, South Eastman)
- Northern (Burntwood, NOR-MAN)

Newsletter Items

The following newsletter items were published by the committee in 2016:

- Reminder to Physicians Regarding Prompt and Aggressive Management of Sepsis in Children
- Documentation of Cause of Death on Death Certificates
- Pediatric Dosing in Resuscitation: The Importance of Weight

Other Committee Activities

The CHSC conducted two Morbidity/Mortality audits in 2016:

- Suicide: Children and Teens
- Sudden infant deaths

The CHSC advocated for the following issues in 2016:

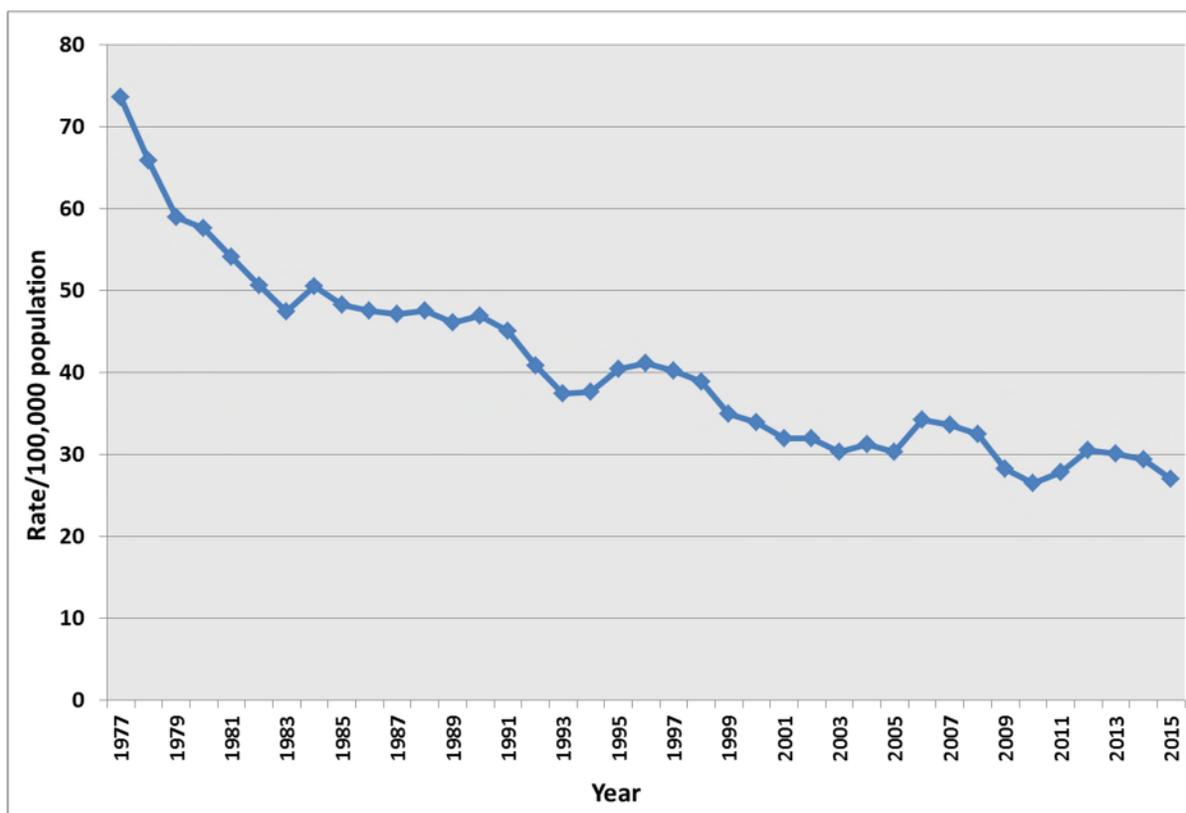
- Safe sleep guidelines, policies and public education
- Sepsis identification and management protocols
- Discharge instructions for families who do not read English or French
- Access to pediatric ECMO in Manitoba

3. Statistical Summary

Mortality Rates

Figure 1 shows the three-year moving average trends in pediatric mortality from 1977 to 2016 for Manitoba residents. *The 2016 data are included in the three-year moving average reported as 2015.*

Figure 1 - MORTALITY RATES
In Children 29 Days to 14 Years (Three-Year Moving Average)



Deaths Grouped by Age and Sex for Manitoba Residents

Table 1 – MORTALITY RATES BY AGE GROUP 2016				
Age Group	Number of Deaths	Population	Rate/100,000	Three-Year Average (2014-2016)
29 days to <1 year	22	16,864	130.5	132.2
1 to 4 years	19	68,357	27.8	30.2
5 to 9 years	7	86,208	8.1	10.7
10 to 14 years	19	80,626	23.6	19.5
Total 29 days to 14 years	67	252,055	26.6	27.0
15 to 17 years	24	50,413	47.6	36.4

Table 2 – MORTALITY RATES BY SEX 2016				
Sex (Age Group)	Number of Deaths	Population	Rate/100,000	Three-Year Average (2014-2016)
Male (29d to 14y)	39	129,356	30.1	28.5
Female (29d to 14y)	28	122,699	22.8	25.3
Male (15y to 17y)	16	26,001	61.5	38.5
Female (15y to 17y)	8	24,412	32.8	34.2

Infant Mortality Rates

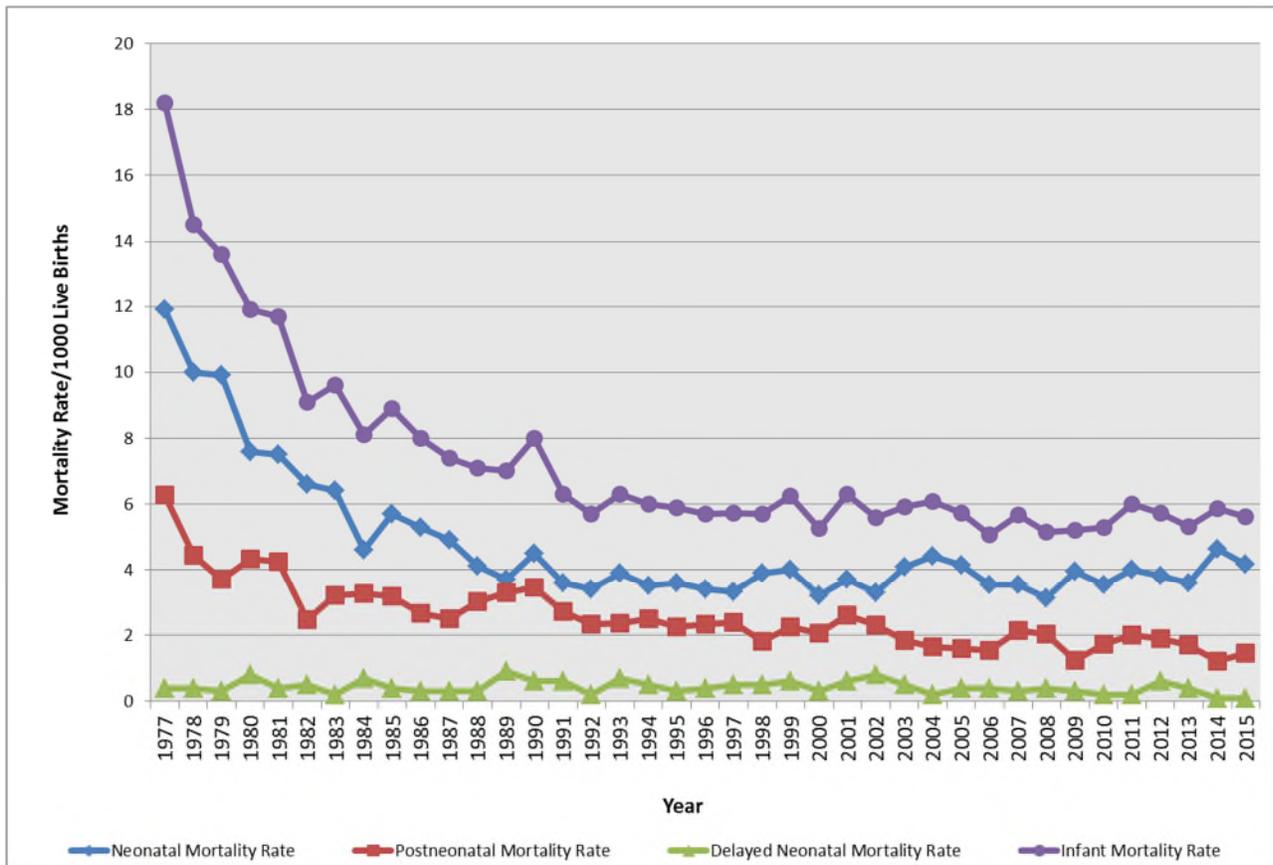
In 2016 there were 96 infant deaths according to Vital Statistics (0-1 yr). There were 22 deaths in the Manitoba population between 29 days and one year of age. The number of live births for Manitoba residents was 16,174. This gives a post-neonatal infant mortality rate of 1.4 per 1,000 live births. There were 69 neonatal deaths in the first 28 days of life, excluding non-residents. The neonatal mortality rate was 4.3 per 1,000 live births. Combining the neonatal mortality rate with the post-neonatal mortality rate gives an overall infant mortality rate of 5.7 per 1,000 live births. This is similar to rates in recent years. These figures include neonates weighing <500 grams born alive.

Notes: (1) The above numbers include all live births and neonatal deaths (hospitals and other locations). (2) In previous years, live births and neonatal deaths were provided by Manitoba Health. These data are no longer available, so the Manitoba Vital Statistics Annual Report 2016/17 was used for live birth and neonatal death data. See https://vitalstats.gov.mb.ca/pdf/2017_vs_annual_report_en.pdf

Infant Mortality Rates Continued

Figure 2 shows Manitoba infant mortality rates over time. Also plotted are neonatal, post-neonatal and delayed neonatal infant mortality rates. When children’s lives are prolonged by technology and they die from neonatal illnesses after 28 days, they are classified as delayed neonatal deaths and become part of the post-neonatal infant mortality statistic. In 2016, four infants less than one year of age were classified as dying from delayed neonatal causes. Infant mortality rates have remained relatively stable for the past decade.

Figure 2 - INFANT MORTALITY RATES



Infant Mortality Rates Continued

Table 3 shows Statistics Canada infant mortality rates for Canada as a whole, and by province. The Statistics Canada figures for Manitoba are slightly different than those presented in this report. Statistics Canada counts infants born in Manitoba to mothers from out of province as being the responsibility of Manitoba. They also count registered births and neonatal deaths weighing less than 500 grams, which are not included in our statistics. Manitoba has had one of the highest infant mortality rates in Canada each year for the last decade.

Province	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
British Columbia	4.1	4	3.7	3.6	3.8	3.9	3.8	3.7	4.3	3.3	3.4
Newfoundland	5.3	7.5	5.1	6.3	5.3	6.3	5.5	6.6	6.2	4.7	4.3
Quebec	5.1	4.5	4.3	4.4	5	4.5	5	4.9	4.4	4.8	4.3
Alberta	5.3	6	6.2	5.5	5.9	5.2	4.3	5.3	5.1	4.7	4.4
Canada	5	5.1	5.1	4.9	5	4.9	4.8	4.9	4.7	4.5	4.5
Ontario	5	5.2	5.3	5	5	4.7	4.9	4.8	4.6	4.4	4.7
Nova Scotia	4	3.3	3.5	3.4	4.6	4.9	4.6	3.3	4.5	4.1	4.9
New Brunswick	4	4.3	3.2	5.8	3.4	3.5	5.7	4.7	4.1	4.0	5.1
Manitoba	6	7.3	6.5	6.3	6.7	7.7	5.9	5.7	6.2	6.4	5.5
Saskatchewan	6.1	5.8	6.2	6.7	5.9	6.8	5.5	7.4	5.9	5.3	5.8
Northwest Territories	10.2	4.1	9.7	15.5	1.4	7.2	4.4	7.5	6.2	6.1	6.2
Yukon	8.2	8.5	5.4	7.8	5.2	0	2.2	2.3	5	9.8	6.8
Prince Edward Island	2.1	5	2	3.4	3.6	4.2	3.5	2.3	1.4	2.1	7.1
Nunavut	13.4	15.1	16.1	14.8	14.5	28.7	21.4	18.2	16.8	12.2	17.7

Source: Statistics Canada (2018). Mortality:Overview, 2014-2016. www150.statcan.gc.ca.

Regional Mortality Rates

Table 4 shows mortality rates by Regional Health Authority (RHA). Note that updated RHA boundaries have been used in our reports since 2013.

Table 4 – REGIONAL MORTALITY RATES 2016 In Children 29 Days to 14 Years				
RHA	Number of Deaths	Population	Rate per 100,000	Three-Year Average (2014-2016)
Northern	17	22,761	74.7	76.6
Interlake-Eastern	7	22,392	31.3	35.8
Southern	12	45,643	26.3	23.7
Prairie Mountain	7	32,161	21.8	20.0
Winnipeg	24	129,098	18.6	19.5
All Manitoba	67	252,055	26.6	27.0

Note: Data are presented in descending order of three-year average rates.

Causes of Childhood Death

Table 5 shows the causes of death in children 29 days to 14 years of age.

For 2016, 67 deaths of Manitoba children 29 days to 14 years of age were reviewed. Injury was the leading cause of death and accounted for 30% of all deaths in this age group. The CHSC also reviewed four deaths of children whose place of residence was out of province.

Table 5 – CAUSES OF DEATH In Children 29 Days to 14 Years		
Cause of Death	Deaths	Rate per 100,000
Injury Total	20	7.9
<i>Unintentional Injury</i>	13	5.2
<i>Intentional Injury*</i>	5	2.0
<i>Undetermined Injury</i>	2	0.8
Infectious Diseases	10	4.0
Respiratory System	7	2.8
Nervous System	7	2.8
SUID	6	2.4
Neoplasm	5	2.0
Congenital Anomaly	4	1.6
Sudden death cause unknown	3	1.2
Perinatal Conditions	3	1.2
Diseases of the Genitourinary System	1	0.4
Diseases of the Digestive System	1	0.4
Total	67	26.6

*Intentional Injury includes homicide and suicide.

Causes of Childhood Death Continued

Table 6 lists the frequency of various causes of post-neonatal infant mortality among Manitoba residents 29 days to one year of age.

Table 6 – CAUSES OF POST-NEONATAL INFANT DEATH In Children 29 Days to 1 Year		
Cause of Death	Deaths	Rate per 100,000
SUID	6	35.6
Perinatal Conditions	3	17.8
Respiratory Diseases	3	17.8
Injury - Total	2	11.9
<i>Injury – intent undetermined</i>	2	<i>11.9</i>
Congenital Anomaly	2	11.9
Infectious Diseases	2	11.9
Diseases of the Nervous System	2	11.9
Sudden death, cause unknown	1	5.9
Digestive System	1	5.9
Total	22	130.5

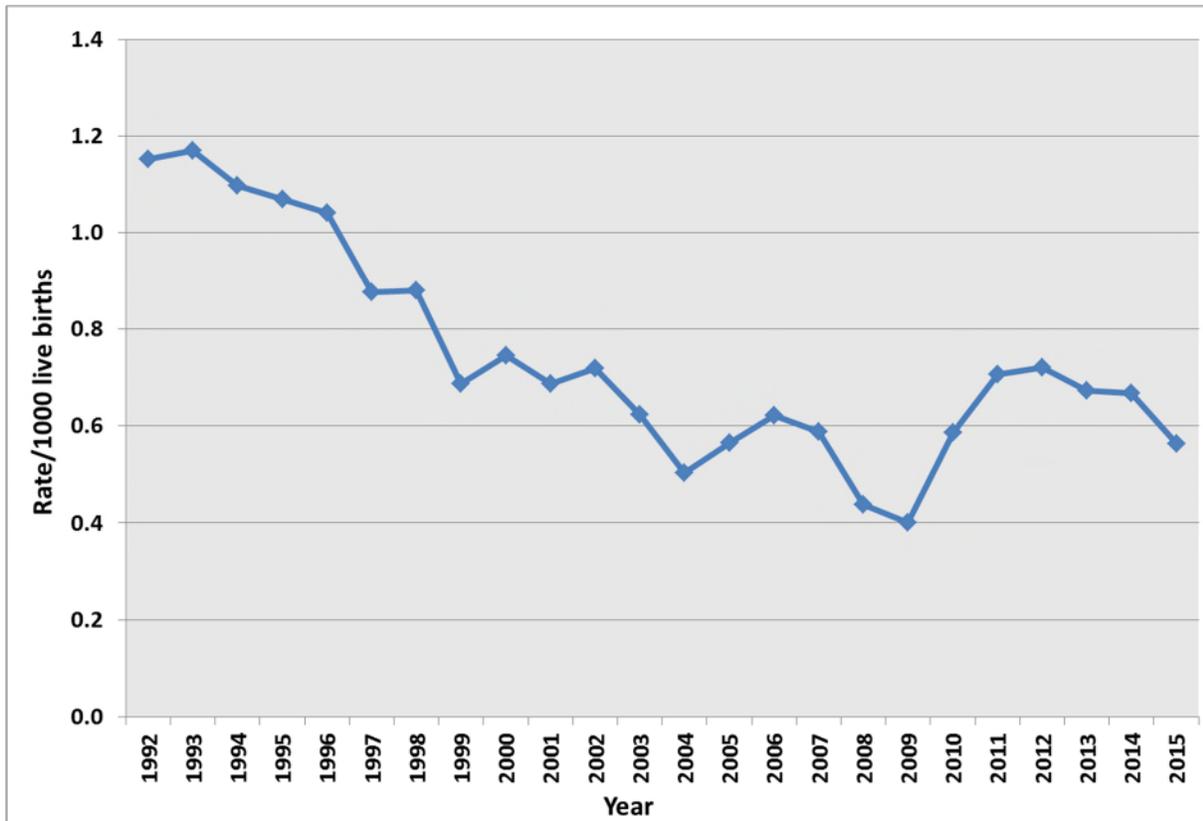
Infant deaths are classified as Sudden Infant Death Syndrome (SIDS) if they remain unexplained by clinical history, death scene investigation (by police) and detailed post mortem examination including skeletal x-rays and toxicology. Sudden Unexpected Infant Deaths (SUID) are those with historical, investigative or post mortem findings which suggest, but do not confirm a cause of death.

Sudden Infant Death

Figure 3 shows the three-year moving average rates for Sudden Infant Death (including SIDS, SUID- sudden unexpected infant death, and suffocation/entrapment in the sleep environment) from 1993 to 2016. There was a consistent decline in sudden infant death rates during this time period until 2010/2011 when the rates rose significantly, followed by a declining trend since 2012.

Among the 6 sudden infant death cases, all were classified as SUID. Five were sleeping on beds or mattresses, and one was in a crib. One infant was sharing a sleep surface. All had modifiable risk factors for SIDS, sudden unexpected infant death and/or suffocation and entrapment.

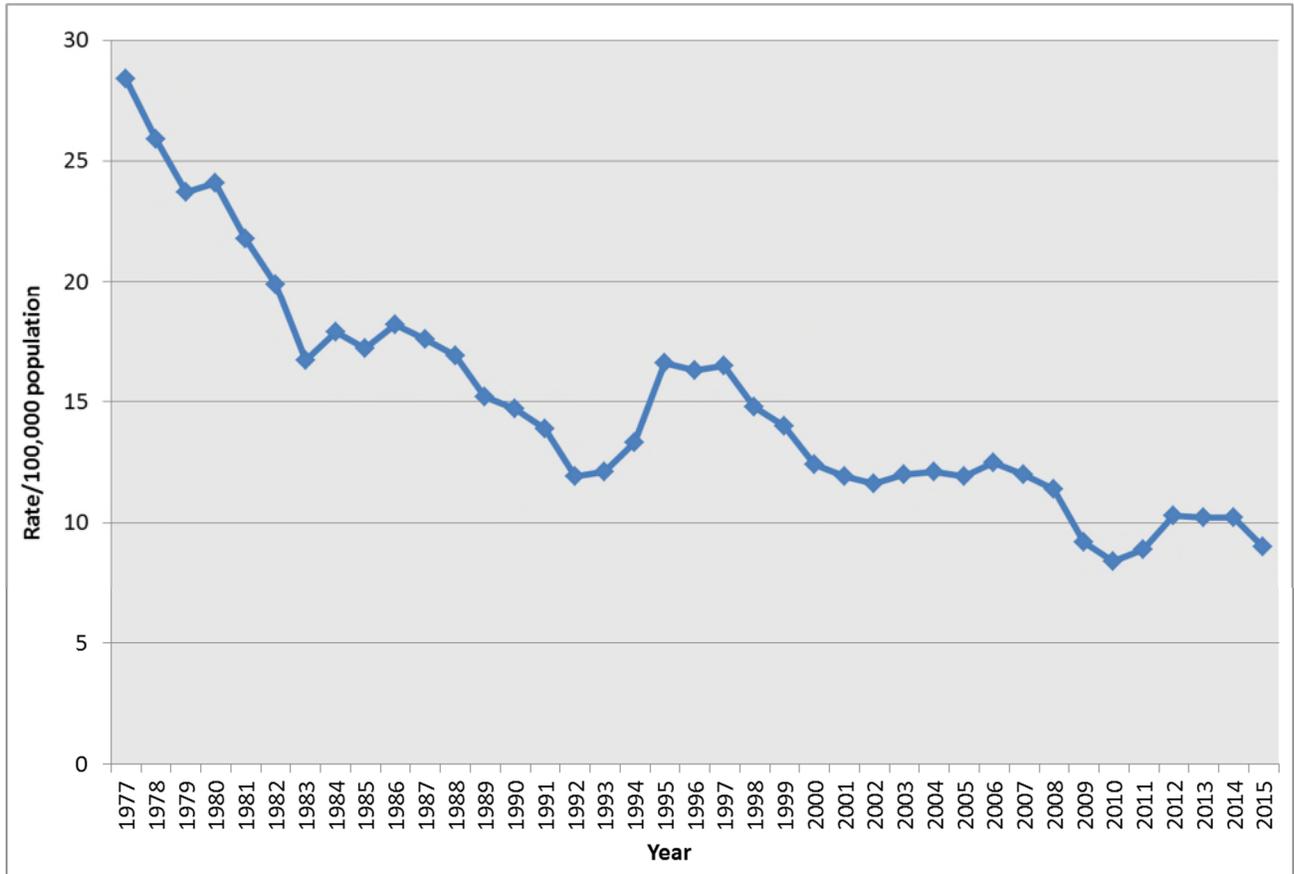
Figure 3 – SUDDEN INFANT DEATH
In Children < 1 Year (Three-Year Moving Average)



Deaths from Injury - Trends

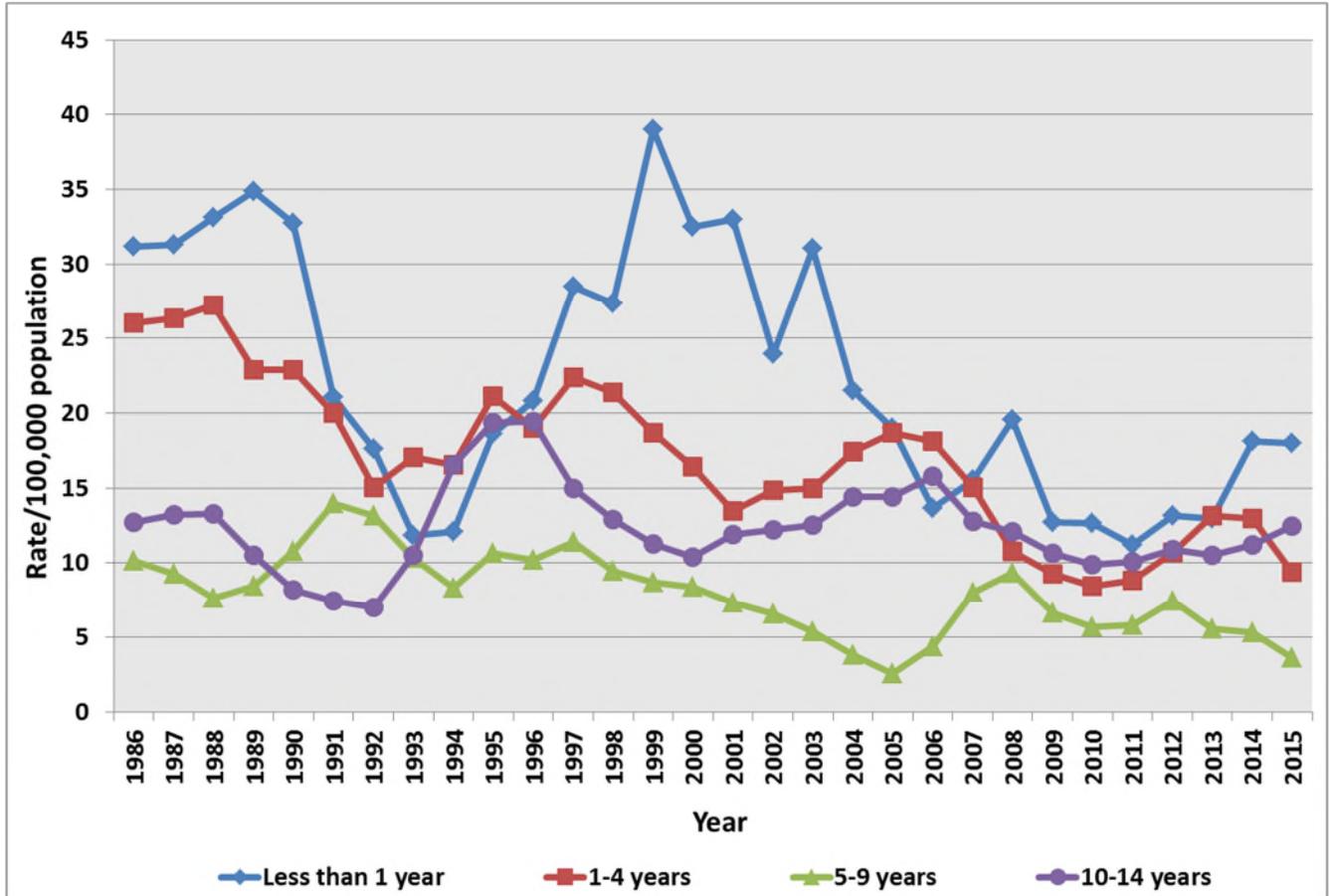
Figures 4 and 5 show the three-year moving average rates for injury deaths (unintentional and intentional combined) for children 29 days to 14 years of age. Data for 2016 are included in the 2015 three-year average (2014-2016).

Figure 4 – MORTALITY RATES FROM INJURY
In Children 29 Days to 14 Years (Three-Year Moving Average)



Deaths from Injury – Trends Continued

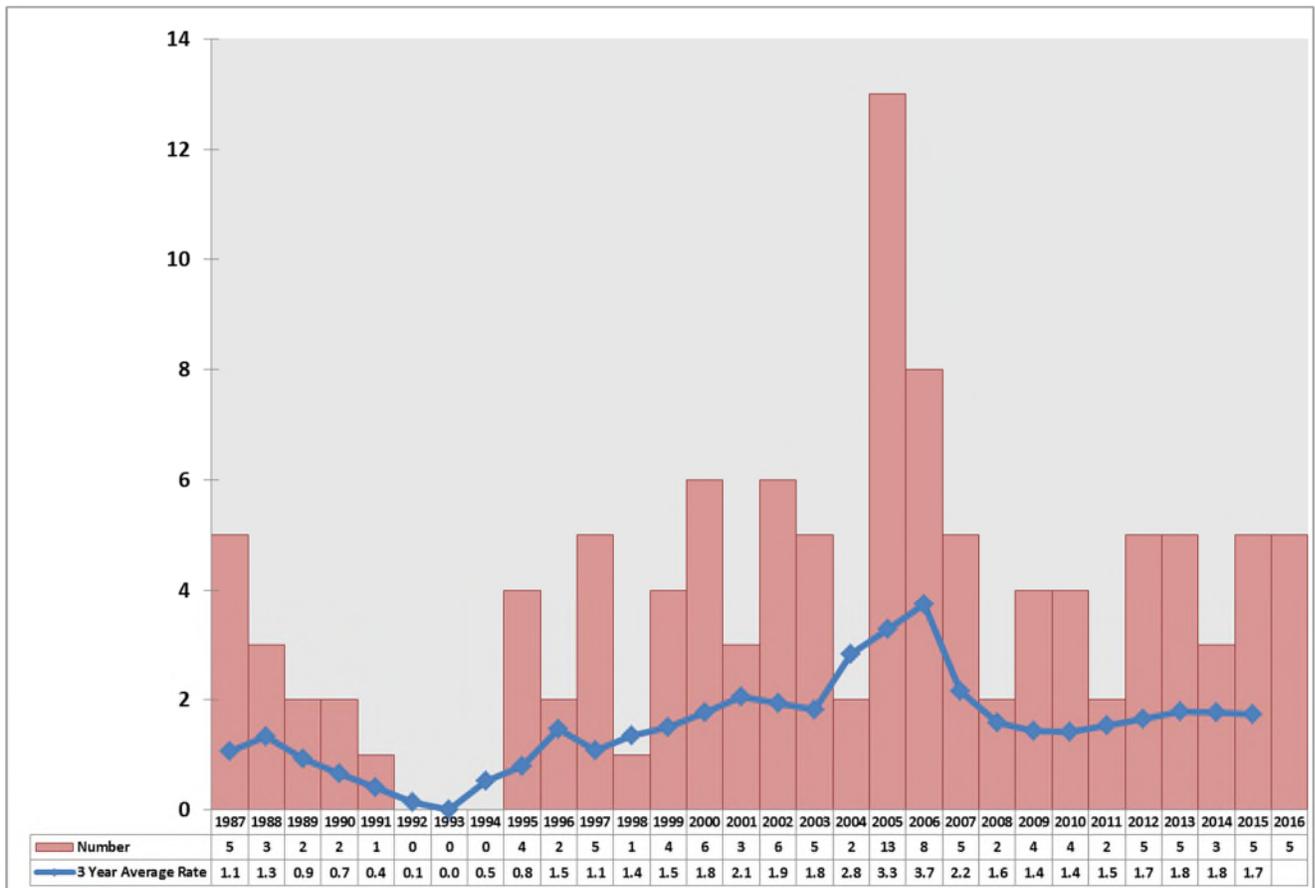
Figure 5 – MORTALITY RATES FROM INJURY BY AGE GROUP
 In Children 29 Days to 14 Years (Three-Year Moving Average)



Deaths from Injury – Trends Continued

Figure 6 shows the annual number of suicides and the three-year moving average rates for suicide for children 14 years of age and younger. Data for 2016 are included in the 2015 three-year average (2014 to 2016). The annual rates of suicide have been stable since 2008.

Figure 6 – SUICIDES AMONG CHILDREN 14 YEARS OF AGE AND YOUNGER
Number Per Year and Three-Year Moving Average Rates



Deaths from Injury – Trends Continued

In 2016, there were 20 deaths due to injury among Manitoba children 14 years of age and under. Injuries caused 30% of all deaths of children between 29 days and 14 years of age (20 of 67).

Table 7 – INJURY-RELATED MORTALITY RATES BY AGE GROUP 2016				
Age Group	Number of Deaths	Population	Rate/100,000	Three-Year Average 2014-2016
29 days - 1 year	2	16,864	11.9	18.0
1 - 4 years	3	68,357	4.4	9.4
5 - 9 years	1	86,208	1.2	3.6
10 - 14 years	14	80,626	17.4	12.4
Total	20	252,055	7.9	9.0

Table 8 – TYPES OF INJURY CAUSING DEATH 2016					
In Children 29 Days to 14 Years					
Unintentional/Undetermined			Intentional		
Cause	Number	Rate	Cause	Number	Rate
Drowning	5	2.0	Suicide	5	2.0
Motor Vehicle	4	1.6			
Off Road Vehicle	2	0.8			
Hypothermia	1	0.4			
House Fire	1	0.4			
Undetermined	2	0.8			
Total	15	6.0	Total	5	2.0

Deaths from Injuries

There were 15 deaths related to unintentional injuries and 5 deaths related to intentional injuries (all suicides). For two injury deaths the intent was undetermined.

Six children died related to transport injuries. Four were motor vehicle passengers, one was an ATV driver and one was a snowmobile driver. Two of the motor vehicle passengers were unrestrained and in two cases restraint use was unknown. Two of the motor vehicle passenger deaths involved a young driver and alcohol use.

Five children died due to drowning. Three children drowned when they fell into natural bodies of water while playing unsupervised. Two children drowned while swimming at a public beach.

One child died in a house fire of unknown cause. It is not known whether smoke alarms were functioning.

One child died due to hypothermia related to cold water immersion after a boating accident.

Autopsies

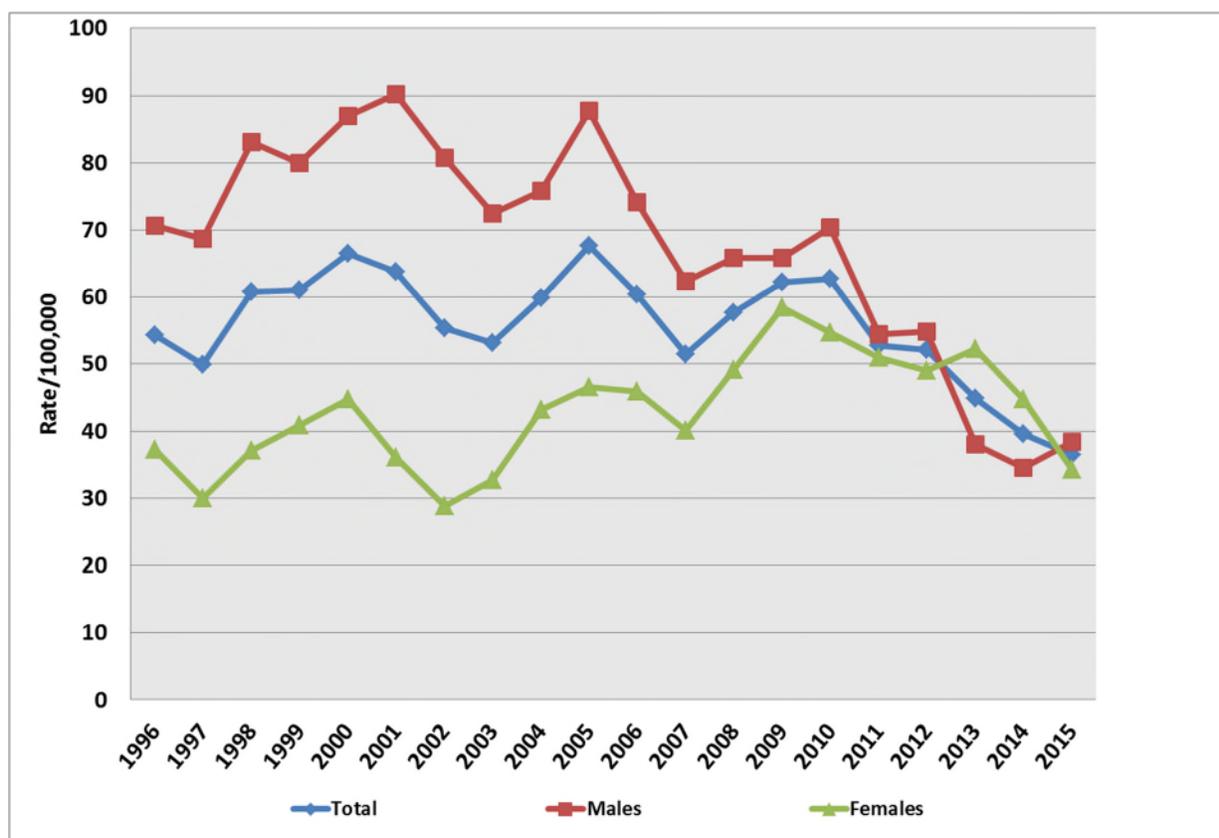
In 2016, 45 of the 67 Manitoba children who died between the ages of 29 days and 14 years had an autopsy (67%). Among teens 15 to 17 years of age, 23 of 24 had autopsies (96%).

4. Teen Deaths, 15 to 17 Years

Since 1994, the Child Health Standards Committee has reviewed deaths of Manitoba youth 15 to 17 years of age. The death rate in 2016 was 47.6 per 100,000, higher than the three-year average rate of 36.4 per 100,000. Male mortality rates were consistently higher than females until 2013, when for the first time since 1996, the three-year average mortality rates for females were higher than the rates for males (2012-2014 and 2013-2015). This trend reversed in 2014-2016, with males again having higher mortality rates than females.

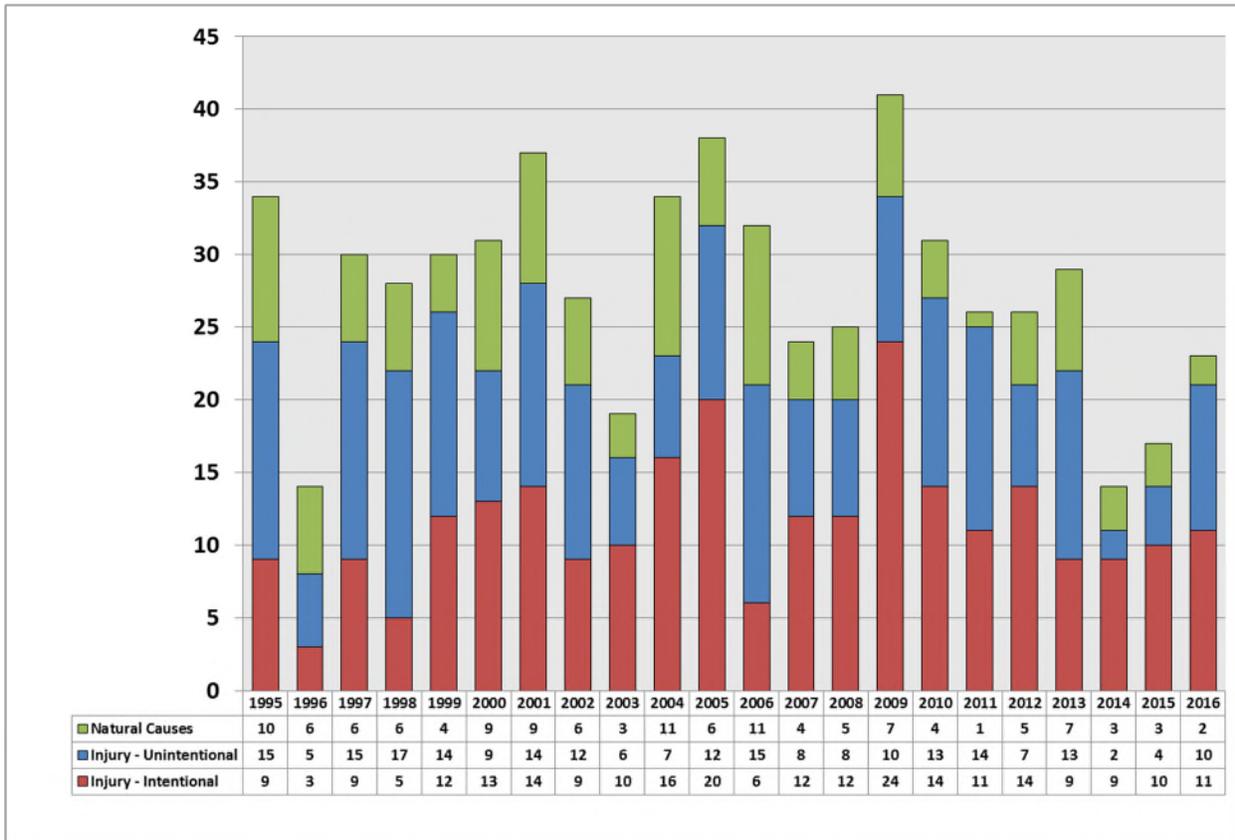
Figure 7 shows mortality rates by sex. **Figure 8** shows the proportion of deaths due to injury and other causes.

Figure 7 - MORTALITY RATES
In Teens 15-17 Years of Age (Three-Year Moving Average)



Teen Deaths Continued

Figure 8 – NUMBER OF DEATHS BY CAUSE (INJURY VS. NATURAL CAUSES)
In Teens 15-17 Years of Age, 1995-2016



Teen Deaths Continued

Table 9 shows the causes of death for this age group and **Table 10** shows the types of injuries causing death.

Table 9 - CAUSES OF DEATH in Teens 15 to 17 years		
	Deaths	Rate per 100,000
Injury	22	43.6
<i>Unintentional Injury</i>	10	19.8
<i>Intentional Injury*</i>	11	21.8
<i>Undetermined Intent</i>	1	2.0
Diseases of the Digestive System	1	2.0
Diseases of the Respiratory System	1	2.0
Total	24	47.6

* Includes homicide and suicide

Table 10 - TYPES OF INJURY CAUSING DEATH in Teens 15 to 17 Years					
Unintentional/Undetermined			Intentional		
	Deaths	Rate/100,000		Deaths	Rate/100,000
Motor Vehicle	5	9.9	Homicide	2	4.0
Drowning	3	6.0			
Poisoning	1	2.0	Suicide	9	17.9
Hypothermia	1	2.0			
Undetermined	1	2.0			
Total	11	21.8	Total	11	21.8

Preventability of Death

The CHSC divides preventability into two categories: (i) preventability of the disease or the injury that caused the death, and (ii) preventability of the outcome once the disease or injury has occurred. Medical care is sometimes involved in the preventability of outcome, and rarely is implicated in the cause of death. Educational action was taken by the committee or another standards committee for cases where medical care could have been improved.

Childhood Deaths

(i) Preventable Cause

In 2016, 24 of the 67 childhood deaths were deemed to have a preventable cause. Twenty-three were injuries (including unintentional injuries, suicide, and homicide) and one was a sudden infant death (unsafe sleep environment). Ten cases were theoretically preventable, five related to significant risk factors in the sleep environment (SUID), with the remaining cases related to injury, infection, and lack of medical care. For three cases the preventability of the cause was unknown.

(ii) Preventable Outcome

One case was classified as having a preventable outcome, where more aggressive care could have modified the outcome. Fourteen cases were classified as having a theoretically preventable outcome, including five cases where there was a delay in seeking care, four cases where more aggressive care could have modified the outcome, and five cases where the parent or guardian could have modified the outcome with better supervision and/or attention. For three cases the preventability of the outcome was unknown.

There were additional cases where the care provided did not alter the outcome but could have been improved:

- Failure to document a core (rectal) temperature at the time of death.*
- Medication errors during resuscitation that did not affect the outcome; these may reflect or include documentation errors.*
- Lack of documentation of significant physical findings relevant to diagnosis, clinical management, and/or discharge counseling/instructions.*
- There were several cases of missing documentation in the medical records reviewed.*

* indicates observations also made in previous years

Teen Deaths

(i) Preventable Cause

In 2016, 22 of the 24 teen deaths were judged to have a preventable cause. All of the preventable deaths were due to trauma (injury), homicide or suicide.

(ii) Preventable Outcome

Four cases were classified as having a theoretically preventable outcome, where closer adult supervision and/or the actions of peers could have altered the outcome.

Educational and Other Actions

The Child Health Standards Committee took 14 educational or other actions for ten cases in 2016. Additional actions taken by other Standards Committees were also reviewed by the committee.

Table 11 - EDUCATIONAL AND OTHER ACTIONS	
Action Taken	
Physician Providers	7
Health Administrators	4
Referrals to other agencies/organizations	3
Total number of actions	14

5. *Recommendations*

The Child Health Standards Committee had the following recommendations related to child health in 2016:

1. That the committee support the work of regional and provincial partners who are developing safe sleep guidelines, policies, and public education.
2. That the committee work with regional and provincial partners to update and disseminate sepsis management guidelines including assessment and management of fever in young infants.
3. That the committee work with regional and provincial partners to consider the communication needs of families who speak languages other than English/French, in particular to communicate discharge instructions and warning signs that indicate an urgent need to seek care.
4. That physicians should be aware of the importance of weight-based dosing for medications in pediatric resuscitation and should be familiar with pediatric resuscitation resources and guidelines.

CHILD HEALTH STANDARDS COMMITTEE

COMMITTEE MEMBERS (2016)

Dr. D. Beer, Paediatrician
Dr. A. Goldberg, Paediatric Nephrologist
Dr. K. Gripp, Paediatrician
Dr. C. Littman, Pathologist
Dr. S. Lum Min, Paediatric Surgeon
Dr. S. Veroukis, Paediatrician
Dr. T. Bodnarchuk, Paediatrician
Dr. B. Magwood, Paediatrician

ADMINISTRATIVE STAFF (2016)

Dr. L. Warda, Paediatrician, Medical Consultant
Dr. T. Babick, Family Physician, Deputy Registrar, CPSM
Mr. J. Martin, Administrative Assistant, Child and Maternal Standards, CPSM

CURRENT ADMINISTRATIVE STAFF (2020)

Dr. L. Warda, Paediatrician, Medical Consultant
Dr. A. Mihalchuk, Family Physician, Assistant Registrar, CPSM
Mr. J. Martin, Administrative Assistant, Child and Maternal Standards, CPSM