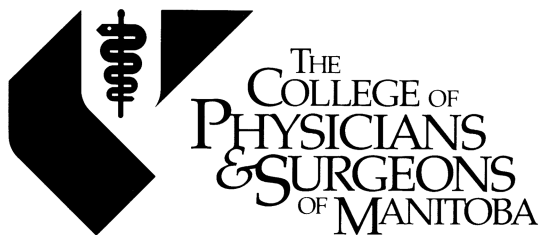


THE
CHILD
HEALTH
STANDARDS
COMMITTEE
2014 ANNUAL REPORT



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 reports are typically published several years after the date of death. This report summarizes deaths which occurred in 2014.

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

Executive Summary 2014

- The Child Health Standards Committee (CHSC) reviewed 86 deaths which occurred in 2014. 65 were children 29 days to 14 years of age, 14 were teens 15 to 17 years of age, 3 were infants 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 26.5 per 100,000 in 2014 compared to 33.8 per 100,000 in 2013 and 30.0 per 100,000 in 2012. The mortality rate for Manitoba teens 15 to 17 years of age was 27.8 per 100,000 in 2014 compared to 56.9 per 100,000 in 2013 and 50.0 per 100,000 in 2012.
- The infant mortality rate was 5.9 per 1,000 live births, which is higher than 2013, when it was 5.3 per 1,000 live births.
- The cause of death was classified as preventable for 24 of the 65 child deaths (37%) and 11 of the 14 teen deaths (79%). Injury (unintentional injury, suicide, homicide) accounted for all of the preventable deaths apart from two sudden infant deaths with unsafe sleep environments.
- Injury was the leading cause of death overall, accounting for 30% of deaths among children and teens. In children 29 days to 14 years of age, the most common causes of injury-related mortality were drowning and transportation-related (pedestrian, off-road vehicle) and suffocation. The most common cause of injury-related mortality in teens was suicide.
- There were 10 suicides in 2014, compared to 12 in 2013 and 17 in 2012. In 2014, seven suicides were teens 15 to 17 years of age and three were 14 years of age or younger.
- In 2014, the CHSC initiated educational action with six physicians with respect to medical care provided. Six referrals were made to health administrators, professional bodies, other organizations or government departments. The committee reviewed additional actions taken by other standards committees.

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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.

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. 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 and Annual Reports 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. On June 1, 2012, the existing 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 item was written by the committee in 2014:

- “Reporting Unfit Drivers”

Other Committee Activities

The CHSC conducted two Morbidity/Mortality audits in 2014:

- Suicide: Children and Teens
- Sudden infant deaths

The CHSC advocated for the following issues in 2014:

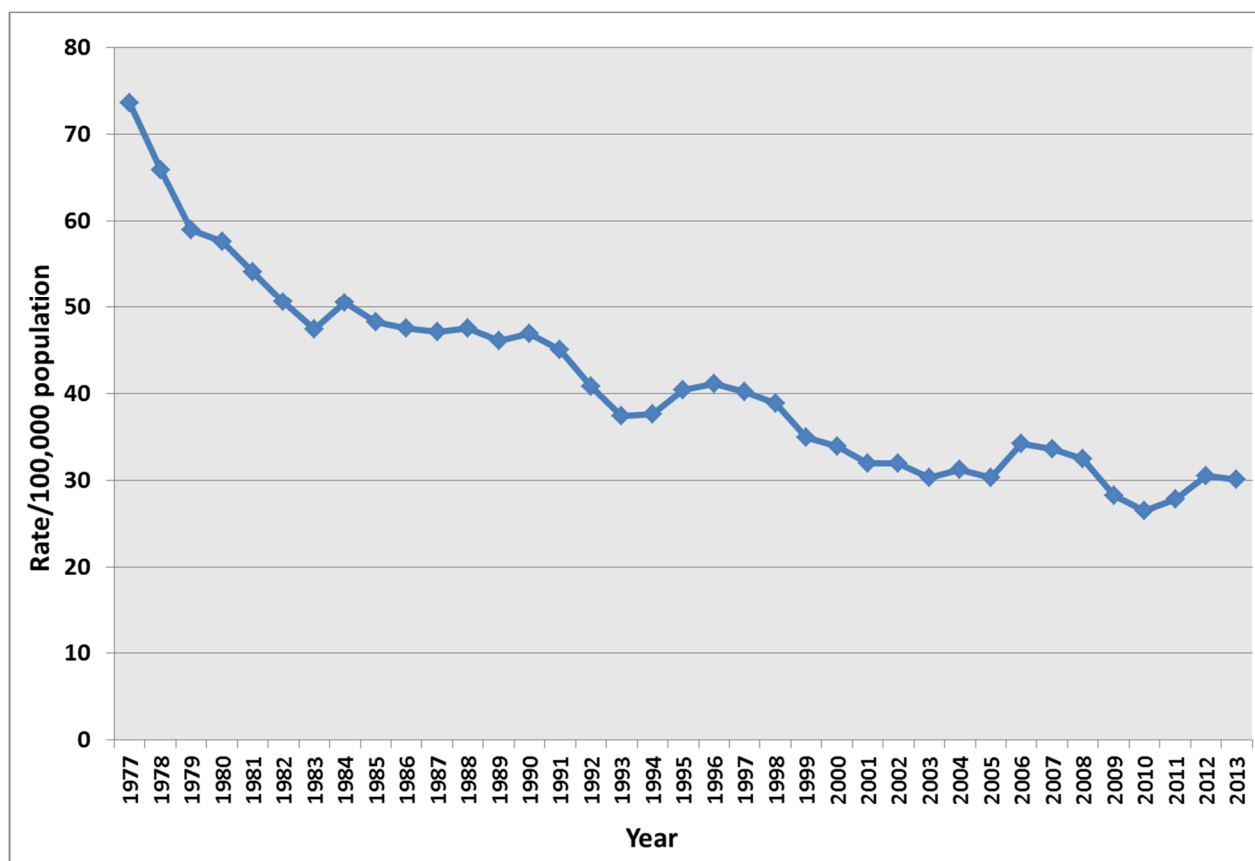
- Safe sleep guidelines, policies and public education
- Raising the Employment and Income Assistance newborn allowance for low income families to adjust for inflation and cost of living, to support purchase of cribs and car seats
- Improvements in pediatric transport care
- Sepsis identification and management protocols

3. Statistical Summary

Mortality Rates

Figure 1 shows the three-year moving average trends in pediatric mortality from 1977 to 2014 for Manitoba residents. *The 2014 data are included in the three-year moving average reported as 2013.*

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 2014				
Age Group	Number of Deaths	Population	Rate/100,000	Three-Year Average (2012-2014)
29 days to <1 year	20	16,413	121.9	162.2
1 to 4 years	20	66,656	30.0	26.7
5 to 9 years	11	82,285	13.4	13.7
10 to 14 years	14	80,155	17.5	22.4
Total 29 days to 14 years	65	245,509	26.5	30.1
15 to 17 years	14	50,295	27.8	44.9

Table 2 - MORTALITY RATES BY GENDER 2014				
Gender (Age Group)	Number of Deaths	Population	Rate/100,000	Three-Year Average (2012-2014)
Male (29d to 14y)	37	125,923	29.4	32.1
Female (29d to 14y)	28	119,586	23.4	27.9
Male (15y to 17y)	6	25,980	23.1	38.0
Female (15y to 17y)	8	24,315	32.9	52.2

Infant Mortality Rates

In 2014 there were 20 deaths in the Manitoba population between 29 days and one year of age. The number of live births based on Manitoba Health registrations was 16,406. This gives a post-neonatal infant mortality rate of 1.2 per 1,000 live births. There were also 76 neonatal deaths in the first 28 days of life. The neonatal mortality rate was 4.6 per 1,000 live births.

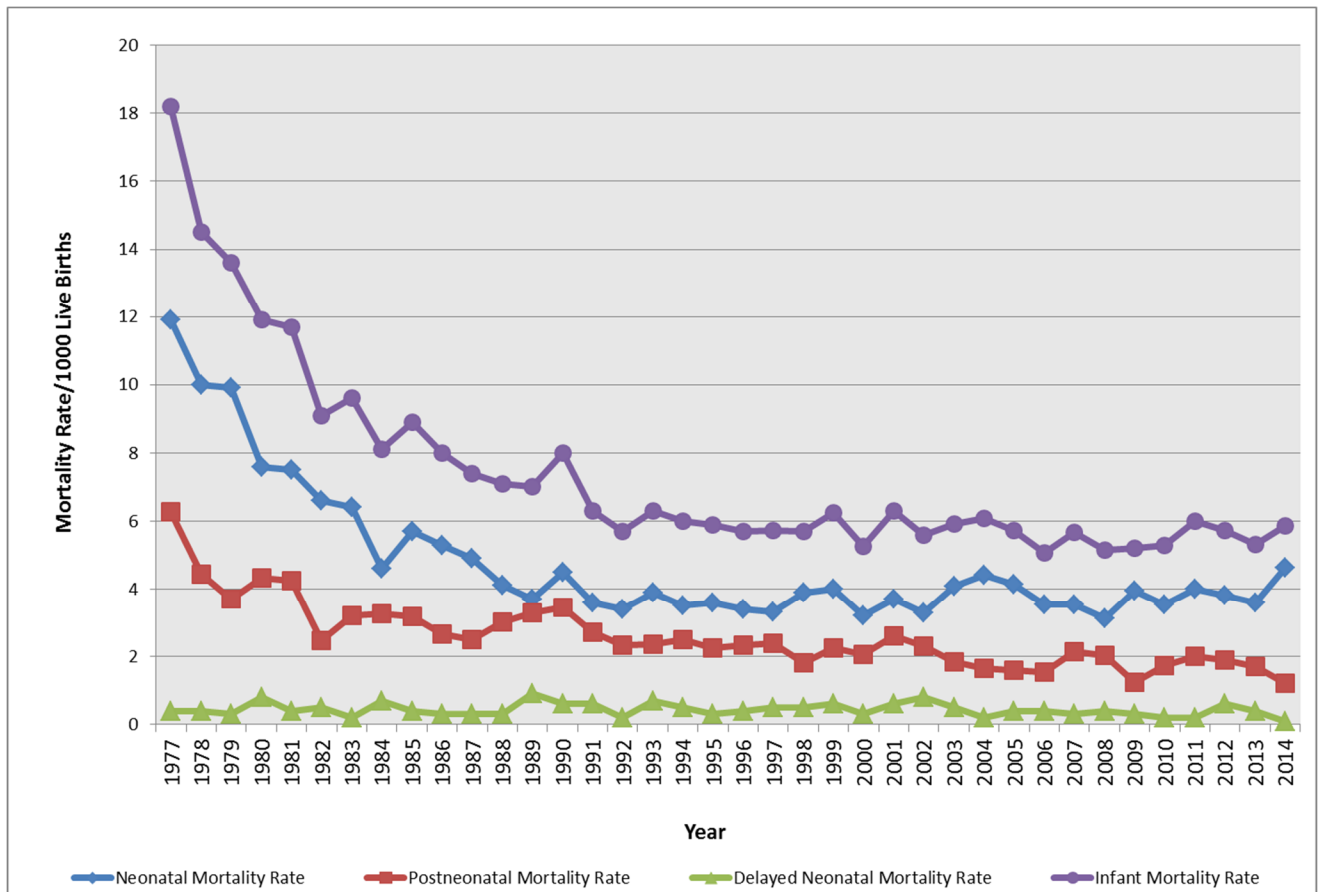
Combining the neonatal mortality rate with the post-neonatal mortality rate gives an overall infant mortality rate of 5.8 per 1,000 live births. This is somewhat higher than rates in recent years. These figures do not include neonates born weighing <500 grams.

Note: the above numbers include only "in hospital" live births and neonatal deaths.

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 2014, two 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 with a slight decline over time.

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	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Prince Edward Island	4.3	2.2	2.1	5	2	3.4	3.6	4.2	3.5	2.3	1.4
New Brunswick	4.3	4.1	4	4.3	3.2	5.8	3.4	3.5	5.7	4.7	4.1
British Columbia	4.3	4.5	4.1	4	3.7	3.6	3.8	3.9	3.8	3.7	4.3
Quebec	4.6	4.6	5.1	4.5	4.3	4.4	5	4.5	5	4.9	4.4
Nova Scotia	4.6	4	4	3.3	3.5	3.4	4.6	4.9	4.6	3.3	4.5
Ontario	5.5	5.6	5	5.2	5.3	5	5	4.7	4.9	4.8	4.6
Canada	5.3	5.4	5	5.1	5.1	4.9	5	4.9	4.8	4.9	4.7
Yukon	11	0	8.2	8.5	5.4	7.8	5.2	0	2.2	2.3	5
Alberta	5.8	6.8	5.3	6	6.2	5.5	5.9	5.2	4.3	5.3	5.1
Saskatchewan	6.2	8.3	6.1	5.8	6.2	6.7	5.9	6.8	5.5	7.4	5.9
Manitoba	7	6.6	6	7.3	6.5	6.3	6.7	7.7	5.9	5.7	6.2
Newfoundland	5.1	6.2	5.3	7.5	5.1	6.3	5.3	6.3	5.5	6.6	6.2
Northwest Territories	0	4.2	10.2	4.1	9.7	15.5	1.4	7.2	4.4	7.5	6.2
Nunavut	16.1	10	13.4	15.1	16.1	14.8	14.5	28.7	21.4	18.2	16.8

Source: Statistics Canada, CANSIM, table 102-0504. Last modified: 2017-11-16.

Regional Mortality Rates

Table 4 shows mortality rates by Regional Health Authority (RHA). Note that the updated RHA boundaries are used here, so direct comparisons cannot be made with some previous reports and three-year average rates are not shown.

Table 4 - REGIONAL MORTALITY RATES 2014 In Children 29 Days to 14 Years			
RHA	Number of Deaths	Population	Rate per 100,000
Northern	18	22489	80.0
Interlake-Eastern	8	22298	35.9
Prairie Mountain	7	31381	22.3
Winnipeg	26	125193	20.8
Southern	6	44148	13.6
All Manitoba	65	245509	26.5

Note: Data are presented in descending order of rates.

Causes of Childhood Death

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

For 2014, 65 deaths of Manitoba children 29 days to 14 years of age were reviewed. Injury was the leading cause of death and accounted for 34% of all deaths in this age group. The CHSC reviewed four deaths of children from out of province.

Table 5 – CAUSES OF DEATH In Children 29 Days to 14 Years		
Cause of Death	Deaths	Rate per 100,000
<i>Unintentional Injury</i>	17	6.9
<i>Intentional Injury*</i>	5	2.0
Injury Total	22	9.0
Infectious Disease	7	2.9
Sudden death cause unknown	6	2.4
Respiratory System	5	2.0
Nervous System	5	2.0
SUID	4	1.6
Neoplasm	4	1.6
Congenital Anomaly	4	1.6
Endocrine, Nutritional, Metabolic	3	1.2
Circulatory System	3	1.2
Diseases of the Digestive System	2	0.8
Total	65	26.5

*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	4	24.4
Sudden death, cause unknown	3	18.3
Congenital Anomaly	2	12.2
Diseases of the Respiratory System	2	12.2
Infectious Diseases	2	12.2
Injury - unintentional	2	12.2
Endocrine and Metabolic	2	12.2
Diseases of the Nervous System	2	12.2
Neoplasms	1	6.1
Total	20	121.9

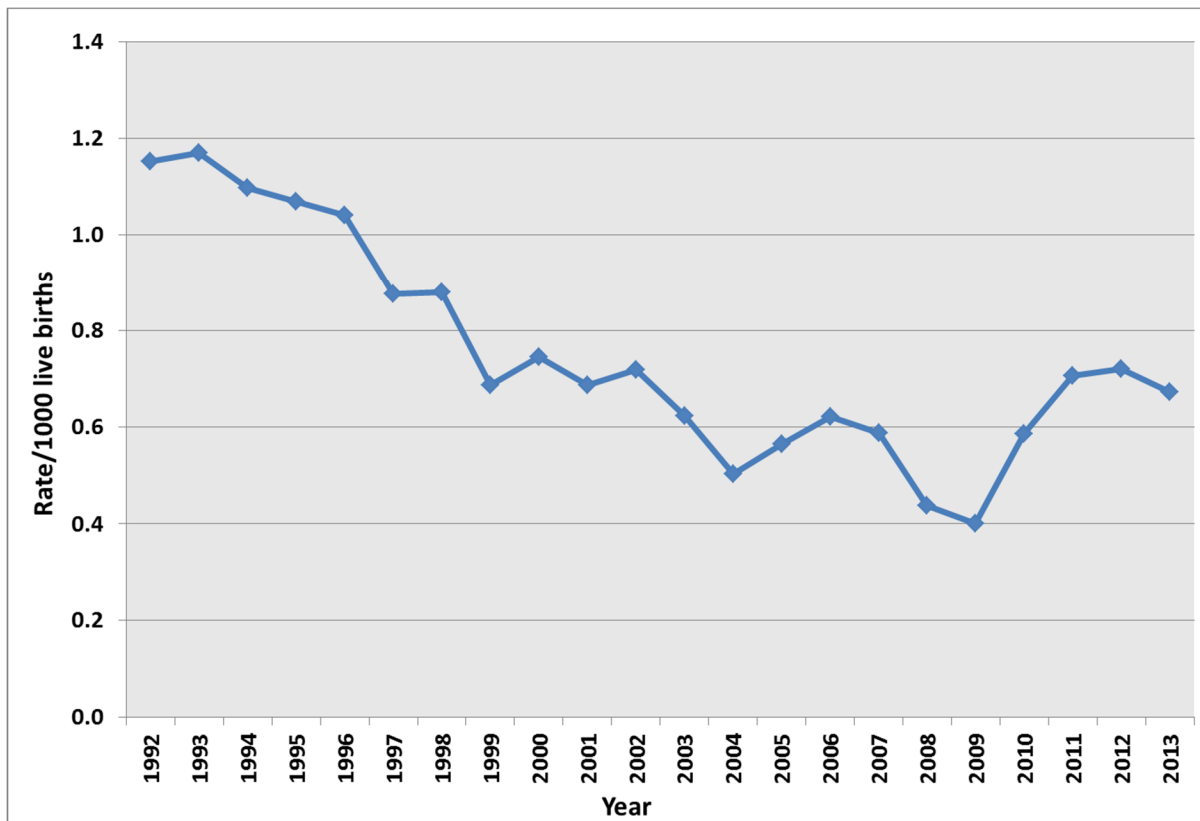
Infant deaths are classified as Sudden Infant Death Syndrome (SIDS) if they remain unexplained by clinical history, death scene investigation (by police) and detailed post mortem examination including skeletal x-rays and toxicology. Sudden Unexpected Infant Deaths (SUID) are those with historical, investigative 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 2014. There was a consistent decline in sudden infant death rates during this time period until 2010 followed by an increase since 2011.

Among the 11 sudden infant death cases, seven were classified as SUID, two as suffocation and two were sudden death, cause unknown. Nine were sleeping on adult beds or mattresses, one was in a playpen and one was in a car seat. Nine infants were sharing a sleep surface (bed or mattress). Ten of the 11 cases had modifiable risk factors for SIDS, sudden unexpected infant death or suffocation and entrapment.

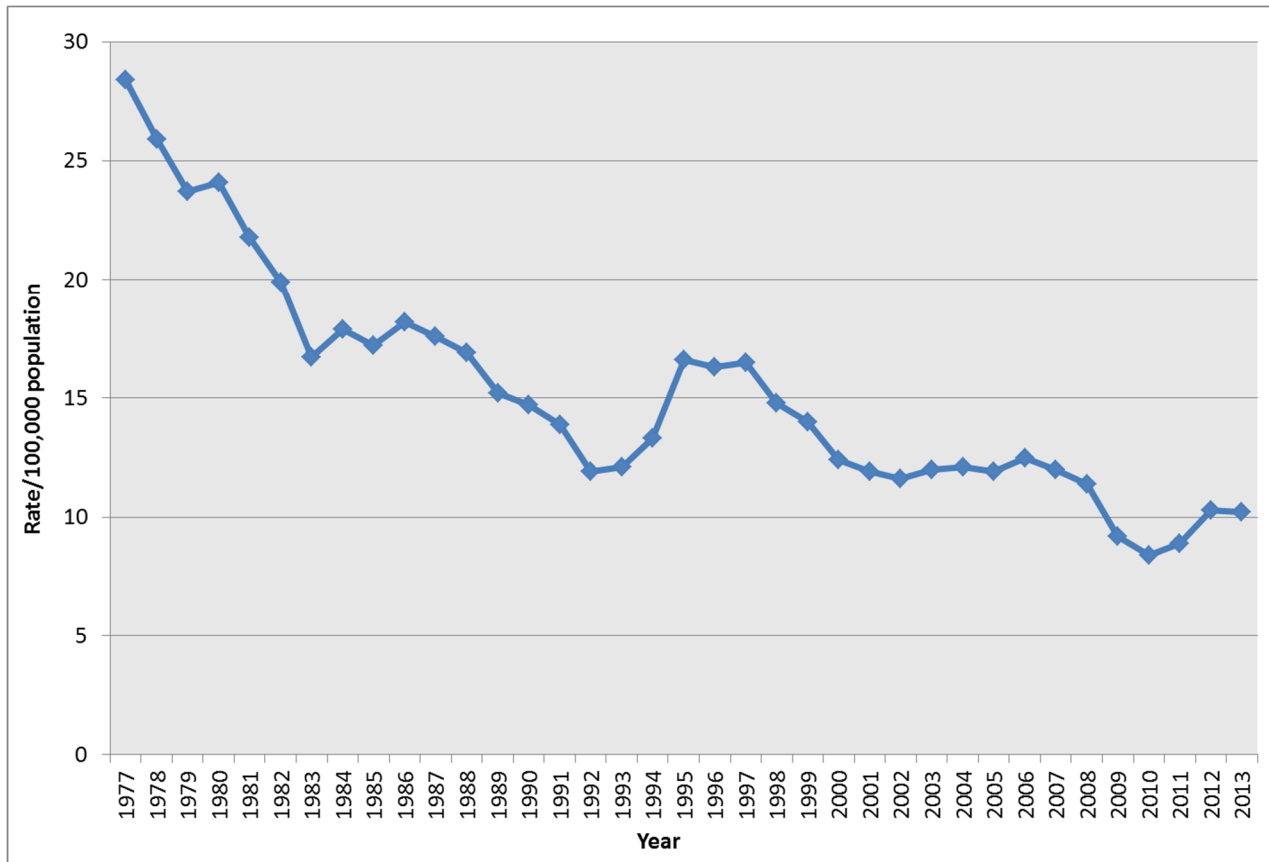
Figure 3 – SUDDEN INFANT DEATH
In Children < 1 Year (Three-Year Moving Average)



Deaths from Injury - Trends

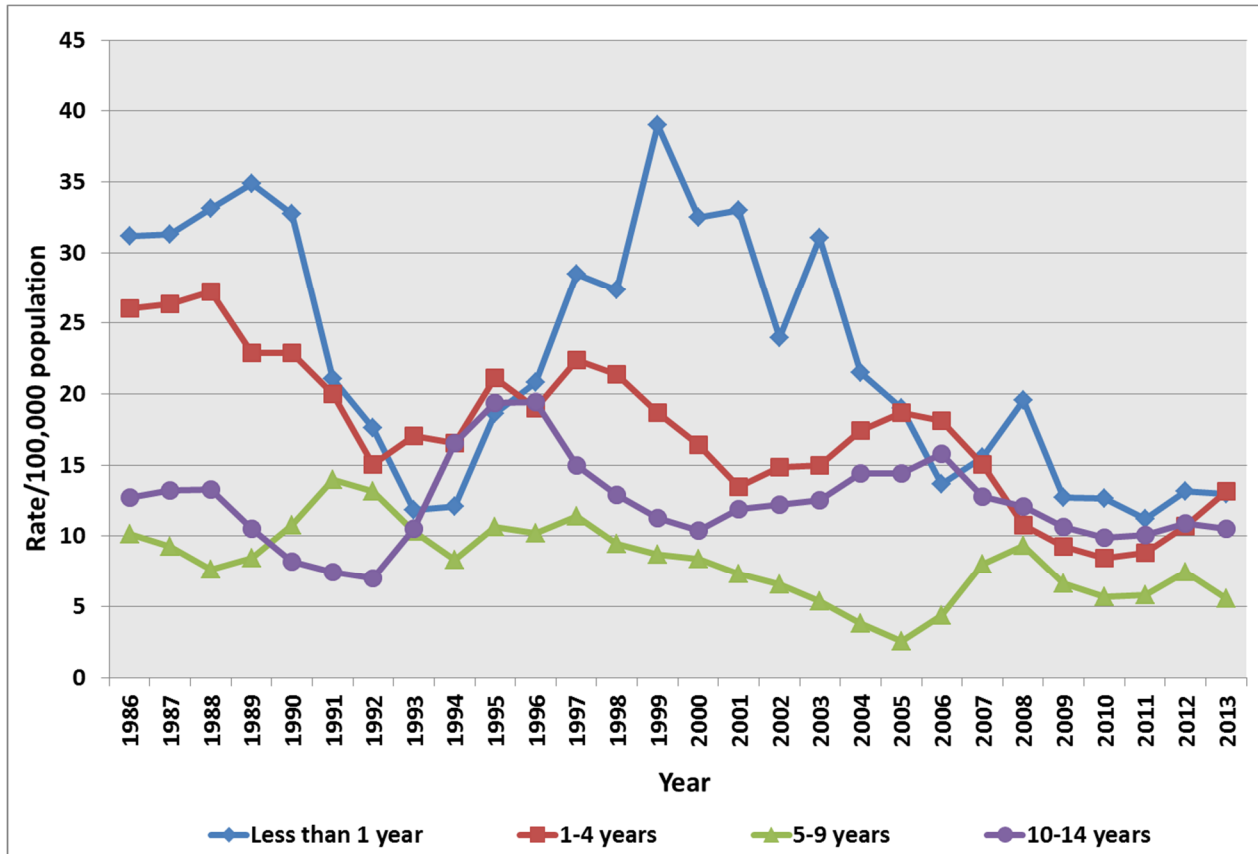
Figures 4 and 5 show the three-year moving average rates for injury deaths (unintentional and intentional combined) for children 29 days to 14 years of age. Data for 2014 are included in the 2013 three-year average (2012-2014).

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



Deaths from Injury – Trends Continued

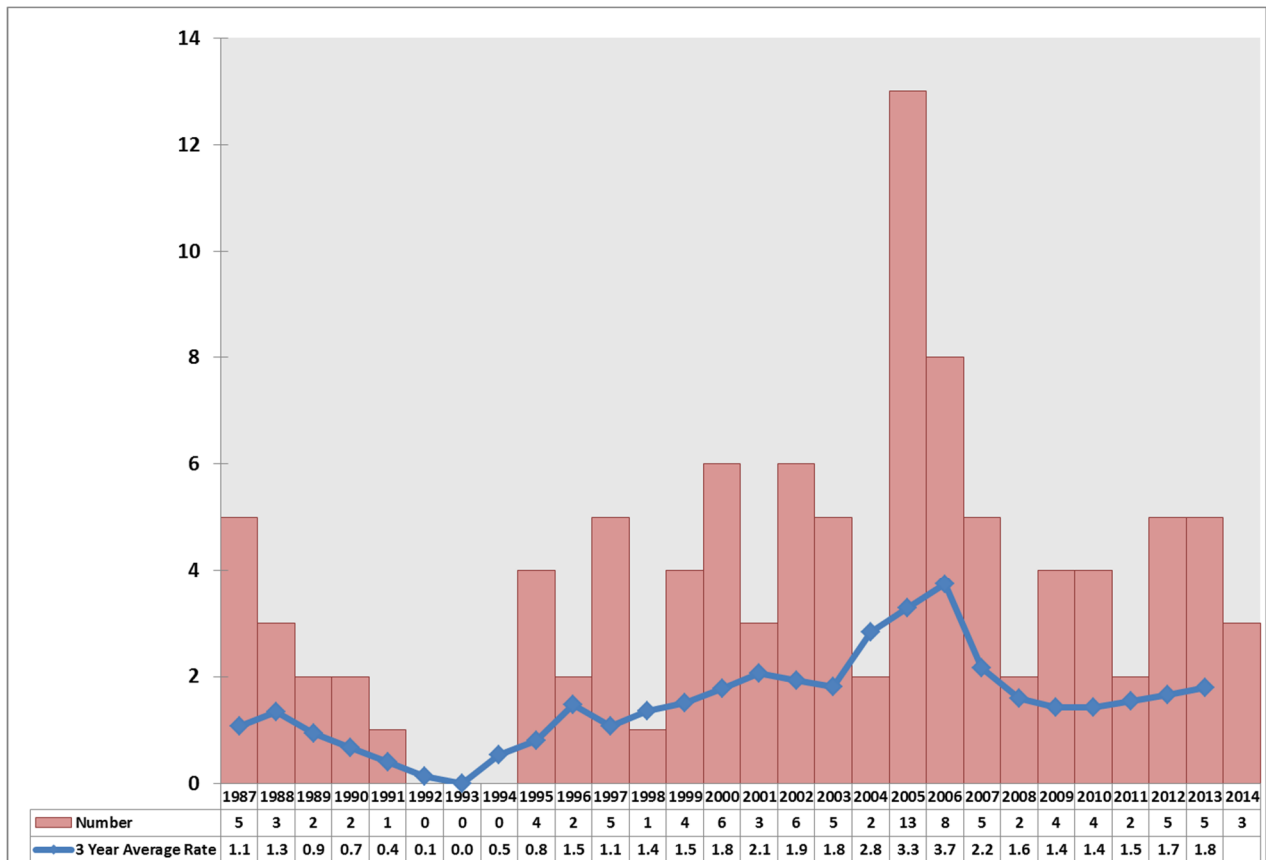
Figure 5 – MORTALITY RATES FROM INJURY BY AGE GROUP
 In Children 29 Days to 14 Years (Three-Year Moving Average)



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 2014 are included in the 2013 three-year average (2012 to 2014). The annual number and rates of suicide had been increasing steadily in this age group in recent years, with a reduction in numbers in 2006 to 2014 as compared to the peak in 2005.

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



Deaths from Injury – Trends Continued

In 2014, there were 22 deaths due to injury among Manitoba children 14 years of age and under. Injuries caused 34% of all deaths of children between 29 days and 14 years of age (22 of 65).

Table 7 – INJURY-RELATED MORTALITY RATES BY AGE GROUP 2014				
Age Group	Number of Deaths	Population	Rate/100,000	Three-Year Average 2012-2014
29 days - <1 year	2	16,413	12.2	16.5
1 - 4 years	10	66,656	15.0	13.6
5 - 9 years	4	82,285	4.9	5.4
10 - 14 years	6	80,155	7.5	10.8
Total	22	245,509	9.0	10.1

Table 8 – TYPES OF INJURY CAUSING DEATH 2014					
In Children 29 Days to 14 Years					
Unintentional			Intentional and Undetermined		
Cause	Number	Rate	Cause	Number	Rate
Drowning	6	2.4	Suicide	3	1.2
Pedestrian	4	1.6	Homicide	2	0.8
Suffocation	4	1.6			
Off road vehicle	1	0.4			
Animal Bite	2	0.8			
Total	17	6.9	Total	5	2.0

Deaths from Unintentional Injuries

There were 17 deaths related to unintentional injuries and 5 deaths related to intentional injuries (three suicides and two homicides).

The most common cause of unintentional injury death was drowning. Six children died due to drowning. These children were 2-4 years of age and drowned when they fell into natural bodies of water while playing with no adult supervision.

Five children died related to transport injuries. Four of these children were struck by vehicles. All were 5 years or younger and were run over when not seen in a driveway, parking lot or back lane. One young child was operating an off-road vehicle and lost control. No helmet in use.

Four children died due to choking or suffocation. One child was found buried in a snowbank, one child choked on a small object, and two infants died as a result of suffocation related to soft bedding and unsafe sleep conditions.

Autopsies

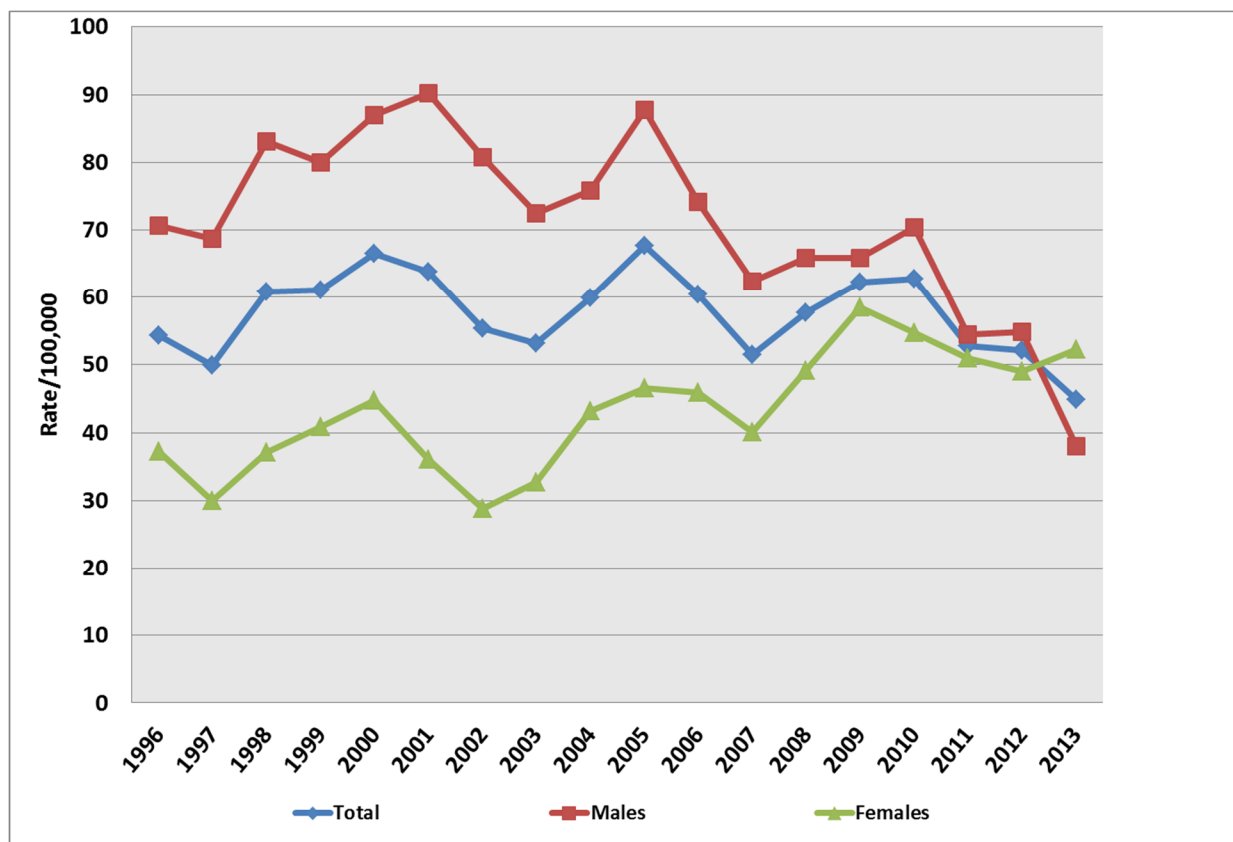
In 2014, 44 of the 65 Manitoba children who died between the ages of 29 days and 14 years had an autopsy (68%). Among teens 15 to 17 years of age, 12 of 14 had autopsies (86%).

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 2014 was 27.8 per 100,000, much lower than the three-year average rate of 44.9 per 100,000. Male mortality rates were consistently higher than females until 2011, and for the first time since 1996, the three-year average mortality rate for females was higher than the rate for males.

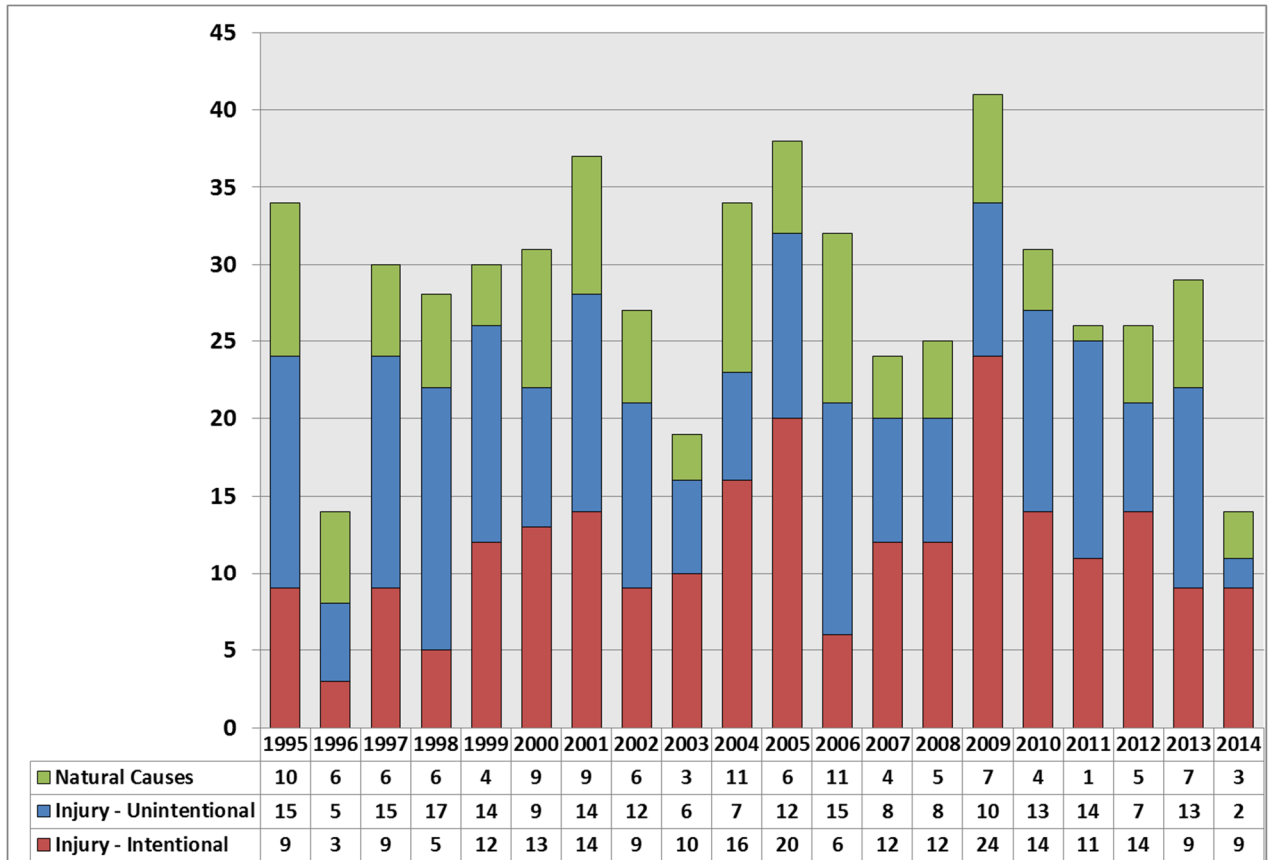
Figure 7 shows mortality rates by gender. **Figure 8** shows the proportion of deaths due to injury and other causes.

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, 1995-2014



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	11	21.9
<i>Unintentional Injury</i>	2	4.0
<i>Intentional Injury*</i>	9	17.9
Neoplasms	2	4.0
Diseases of the Circulatory System	1	2.0
Total	14	27.8

* Includes homicide and suicide

Table 10 - TYPES OF INJURY CAUSING DEATH in Teens 15 to 17 Years					
Unintentional			Intentional		
	Deaths	Rate / 100,000		Deaths	Rate / 100,000
Pedestrian	1	2.0	Homicide	2	4.0
Hypothermia	1	2.0	Suicide	7	13.9
Total	2	4.0	Total	9	17.9

Teen Deaths Continued

In 2014, there were three deaths due to natural causes. Two deaths were due to unintentional injuries, including one pedestrian injury and one case of hypothermia. There were 9 intentional injury deaths, including seven suicides and two homicides. All but one of the suicides were by hanging; one was caused by an overdose/poisoning. Alcohol was noted at autopsy in three suicide cases.

5. *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 2014, 24 of the 65 childhood deaths were deemed to have a preventable cause. Twenty-two were injuries (including unintentional injuries, suicide, and homicide) and two were sudden infant deaths with unsafe sleep environments. Two cases were theoretically preventable, related to significant risk factors in the sleep environment (SUID).

(ii) Preventable Outcome

There were no cases classified as having a preventable outcome. Seventeen 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, one case where proper use of a car seat could have modified the outcome, and seven cases where the parent or guardian could have modified the outcome with better supervision and attention.

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 2014, 11 of the 14 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

One case was classified as having a preventable outcome, related to adult supervision. Two deaths were classified as having a theoretically preventable outcome, including one case of hypothermia and one case where earlier diagnosis and management could have modified the outcome. In two cases, closer adult supervision could have altered the outcome.

Educational and Other Actions

The Child Health Standards Committee took 12 educational or other actions for six cases in 2014. Additional actions taken by other Standards Committees were also reviewed by the committee.

Table 11 - EDUCATIONAL AND OTHER ACTIONS	
Action Taken	
Physician Providers	6
Health Administrators	2
Referrals to other agencies/organizations	4
Total number of actions	12

6. *Recommendations*

The Child Health Standards Committee had the following recommendations related to child health in 2014:

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 postoperative warning signs and discharge instructions.

CHILD HEALTH STANDARDS COMMITTEE

COMMITTEE MEMBERS (2014)

Dr. D. Beer, Paediatrician
Dr. M. Feierstein, 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

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Dr. T. Babick, Family Physician, Deputy Registrar, CPSM
Mr. J. Martin, Administrative Assistant, Child and Maternal Standards, CPSM

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Dr. T. Babick, Family Physician, Deputy Registrar, CPSM
Mr. J. Martin, Administrative Assistant, Child and Maternal Standards, CPSM