College of Physicians and Surgeons of Manitoba

Child Health Standards Committee

Report of Activities: 2019-2020

The Central Standards Committee of the College of Physicians and Surgeons of Manitoba (CPSM) established a subcommittee to review all pediatric deaths in Manitoba in 1976. The mandate of the Child Health Standards Committee (CHSC) is to maintain and improve the quality of medical practice as related to Child Health through peer review and analysis, and through education, rather than discipline. The CHSC reviews all deaths of children and youth between the ages of 29 days and 17 years in order to improve the quality of pediatric care and to advocate for the health of Manitoba children by informing government and other public agencies of recommendations to improve legislation or public policy. The committee also reviews cases referred to the College regarding pediatric standards of care.

The CHSC is pleased to present the following summary of activities for 2019 and 2020.

Cases Received

CPSM receives notification of all pediatric deaths from the Office of the Chief Medical Examiner. In 2019/2020 we received notification of 99 deaths that occurred in 2019 and two deaths that occurred in 2020 (the latter due to delays in reporting of deaths to the committee related to COVID).

Once cases are received an initial database entry is created and relevant records are requested from hospitals, physicians' offices and the Office of the Chief Medical Examiner.

Cases Reviewed

The CHSC reviewed 134 cases in 2019 and 80 cases in 2020. The Medical Consultant for the CHSC reviews all child and youth deaths in Manitoba. Through this review, the CHSC can ensure that systems issues are addressed in the province of Manitoba, including issues in health care services, mental health, pediatric transport, and child protection. The committee considers all aspects of preventability, and communicates with the health care system and with various levels of government when changes could be made to improve child health and reduce injuries and preventable illnesses in children.

Suicide Reviews

The CHSC reviews all child and youth suicides with an invited Child and Adolescent Psychiatrist. In 2019 the committee reviewed 22 suicides that occurred in 2017. In 2020 the committee reviewed 17 suicides that occurred in 2018.

Child Mortality Review reports

The 2016 and 2017 Child Mortality Review reports were completed in 2019/2020, summarizing the deaths of children and youth that occurred in 2016 and 2017. These reports are appended to this report. Bringing case reviews from a certain calendar year to closure takes time. The committee is notified of deaths 2-3 months after the date of death. Multiple records are requested for review, including all healthcare provided for two years until the date of death (outpatient, inpatient, and transfer records) as well as reports from other standards committees, the autopsy, and Report of the Medical Examiner. Autopsy reports may not be finalized for many months following a death, particularly for cases where law enforcement is involved. Once all the records have been received, the Medical Consultant analyzes the findings and prepares cases for review by the committee. After the committee has reviewed each case, actions are taken as recommended by the committee, such as letters to physicians and other health care providers, regulatory bodies, health care facilities, and government departments. The flow of cases through the OCME and other standards committees has slowed considerably during the pandemic, and closure of 2018-2020 cases is expected to be delayed as a result.

Quality of Pediatric Care Initiatives

The committee worked on the following quality of care initiatives in 2019/2020:

- Pediatric Transport advice and systems: improving communication and physician awareness. Provincial stakeholders including MTCC, Child Health Transport, Social Northern and Ambulatory Pediatrics, and regional Pediatric leads were consulted in order to identify current processes and transport recommendations, and a CPSM newsletter item was published.

- Manitoba Poison Control Centre (MPC): improving services in remote communities and in critical cases. As a result of feedback from the CHSC, a priority call line was established for Manitoba callers and for critically ill patients. A new process was established for the MPC Medical Toxicologist on call to provide real-time telephone consultation to Manitoba health care providers caring for critically ill poisoned patients. Improvements were made to the MPC calcium channel blocker overdose algorithm.

- Anaphylaxis: the Medical Consultant worked with Child Health (Allergy, Pharmacy, Acute Care, Emergency), Manitoba EMS, Community Pediatrics, Primary Care and the College of Pharmacists to update and standardize the management of pediatric anaphylaxis in Manitoba. An anaphylaxis management guideline and emergency action sheet were developed, and pediatric content was provided for the Manitoba Health Anaphylaxis Clinical Practice Guideline that was developed for COVID-19 vaccine clinics.

- Manitoba Advocate for Children and Youth infant mortality analysis: the Medical Consultant contributed to the infant mortality report and a webinar series for professionals and community practitioners across the province, focusing on unsafe sleep conditions and systems factors for prevention.

Newsletter Items

The CHSC drafted four newsletter items in 2019/2020 for Manitoba physicians, published in the CPSM newsletter:

- Pediatric advice and transport for Manitoba children and youth (2020)
- Recognition and management of hemolytic uremic syndrome (2020)
- Hypoglycemia: Detection, management and transport advice for sick infants (2019)
- Starting antidepressants in youth: timing of follow-up (2019)