CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Annual Report 2014–2015

Government
of South Australia

GPO Box 1152
ADELAIDE SA 5001

T 08 8463 6451
F 08 8463 6444

E cdsirc@sa.gov.au
W www.cdsirc.sa.gov.au

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Letter of Transmission

Hon Susan Close MP
Minister for Education and Child Development

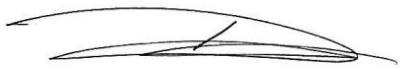
Dear Minister

I submit to you for presentation to Parliament, the 2014-15 Annual Report of the South Australian Child Death and Serious Injury Review Committee which has been prepared pursuant to Part 7C of the Children's Protection Act 1993.

This report highlights the Committee's activities in fulfilling its statutory obligations.

In compliance with the Public Sector Act 2009 and the Public Finance and Audit Act 1987, a further report concerning the management of human resources and financial issues of the Committee has been submitted as part of the Annual Report of the Department for Education and Child Development 2014-15.

Yours faithfully



Dymphna Eszenyi

Chair
Child Death and Serious Injury Review Committee

31 October 2015

Chair's Foreword

I am pleased to present the Committee's tenth Annual Report to Parliament under Part 7C of the *Children's Protection Act 1993.*

In the past year, much public attention has been given to the ways in which South Australia, both government and community, seeks to protect and nurture its children. The actions of systems, agencies and individuals have been scrutinised.

As these issues receive such public attention, I find it heartening to see that the Committee does not stand alone in its views about what is important to protect children from harm and to nurture their safety and wellbeing.

I am thinking in particular about the conclusions of the Coroner in his report into the death of Chloe Valentine. More recently I attended the Healthy Development Adelaide Oration by Professor Fiona Arney who directs the Australian Centre for Child Protection. She identified at least three critical areas of reform necessary if the child protection system is to provide an effective service that keeps children safe from harm. These three areas of reform: preventing and responding to cumulative harm and repeat involvement; supporting Aboriginal children and their families; and high quality planning and implementation of services for families, have been at the basis of the Committee's reviews and recommendations for many years.

I have read the Council for the Care of Children's most recent report about their conversations with children with disability. I was not surprised to find that many of the issues highlighted in this report: the impact of the NDIA on service provision; the ways in which the education system responds to children with disabilities; and, the use of models like 'Team around the Child' were closely aligned to the issues arising from the Committee's reviews.

I continue to believe that much can, and should, be learned from the review of a child's death. At times however, the Committee experiences some frustration because we are limited in our ability to disclose the information that we have about the serious nature of the circumstances that lead to a death or serious injury. Without such disclosure it is difficult to provide a context that would motivate agencies to address the issues the Committee has identified, and work to prevent future deaths.

The Committee has made a submission to the current Child Protection Systems Royal Commission suggesting legislative change to enable it to communicate that context to

relevant agencies, while protecting information about individual cases from further publication.

I thank my colleagues on the Committee who continue to devote many hours of their personal time to the Committee's work. I would like to acknowledge the contribution of Professor Roger Byard, one of the Committee's founding members, whose service ended in 2014. Despite his resignation, the Committee continues to seek Professor Byard's advice as a pathologist, and an international expert, on the deaths of infants and children.

In August 2014, we were saddened by the unexpected death of Helen Wighton, another of our founding members, whose passion for and commitment to the rights of children inspired all of us.

On behalf of the Committee I extend my condolences to the families and friends who have experienced the death of a child and to the communities and professionals who cared for them.

I commend this report to you and encourage all those who seek to care for children and keep them safe to read it. I share the Committee's hope that the report will be of assistance in guiding your efforts to keep children safe and well.

DJ Eszenyi
Chair

Child Death and Serious Injury Review Committee

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Glossary

ABS	Australian Bureau of Statistics
Act	*Children's Protection Act 1993*
AIHW	Australian Institute of Health and Welfare
ANZCDR&PG	Australian and New Zealand Child Death Review and Prevention Group
ARIA+	Index of Remoteness and Accessibility, Australia
ATSI	Aboriginal and Torres Strait Islander
CAMHS	Child and Adolescent mental Health Service
CDSIRC	Child Death and Serious Injury Review Committee
Children	In this report 'children' includes infants, children and young people from birth up to 18 years
Coroner	State Coroner SA
ICD–10	International Classification of Disease (Version 10)
IMR	Infant Mortality Rate
Infant	A child less than one year of age
IRSD	Index of Relative Socio-economic Disadvantage
SEIFA IRSD	Socio-Economic Indexes for Areas, Index of Relative Socio-economic Disadvantage (IRSD)
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy
WCHN	Women's and Children's Health Network
WHO	World Health Organization

Acknowledgements

The Committee wishes to thank the following individuals and organisations for making themselves available to support the Committee's work:

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) representatives attending ANZCDR&PG meetings who share insights gained from their own jurisdictions
- Department for Communities and Social Inclusion which continues to provide technical advice and support for the Committee's database, and assistance with records management
- Department for Education and Child Development for its support with administrative, financial and human resource management
- Department of Education and Child Development, Data Management and Information Systems, Edward Trojanowski, Demographer
- Kidsafe SA
- National Centre for Health Information Research and Training, Brisbane, especially Ms Sue Walker, Director
- Office of Births, Deaths and Marriages
- SA Health Epidemiology, Systems Performance Division
- SA Health, Health Statistics Unit, Kamalesh Venugopal, Unit Head
- SA Health Maternal and Perinatal Mortality Committee
- SIDS and Kids SA
- State Coroner, especially Mr Mark Johns, Coroner and staff
- Women's and Children's Health Network Records Management team
- Chief Executives and Senior Officers from the Department of Education and Child Development, the Department for Communities and Social Inclusion, SA Health and SA Police for contributing to the Committee's understanding of service delivery in their departments

Committee Members 2014-15

Chair

Ms Dymphna (Deej) Eszenyi

Members

Professor Roger Byard AO	until 9 October 2014
Mr Alwin Chong	
Ms Lynne Cowan	
Ms Angela Davis	
Dr Mark Fuller	from 25 June 2015
Ms Dianne Gursansky	
Ms Michelle Hasani	
Mr Barry Jennings QC	
Dr Deepa Jeyaseelan	from 25 June 2015
Dr Margaret Kyrkou OAM	
Mr Tom Osborn APM	
Ms Nicole Stasiak	
Dr Nigel Stewart	
Ms Trish Strachan	
Ms Barbara Tiffin	

Executive Summary

This is the tenth Annual Report of the Child Death and Serious Injury Review Committee.

Purpose and establishment

The Committee contributes to efforts to prevent death or serious injury to children in South Australia. It was established by the *Children's Protection Act 1993* (the *Act*) in February 2006.

The Committee reviews the circumstances and causes of death and serious injury to children. It makes recommendations to Government for changes to legislation, policies and procedures that may help prevent similar deaths or serious injuries.

Reviews and recommendations

The Committee's 2014-15 reviews have highlighted that:

- Children under the Guardianship of the Minister are entitled to responsive care that provides them with the best opportunity to become adults who can participate in a meaningful way in society, and effectively parent their own children. To achieve this they may need sustained support beyond 18 years of age.
- Children with disability need pro-active, holistic service planning and provision that takes into account the complexity of their needs and the capacity of their family to provide for those needs both now and in the long-term.
- To help prevent suicide in young people, there must be a broad spectrum of prevention and intervention programs that do not focus solely on mental health services.
- Where there is neglect of children good service provision starts with recognizing the complex needs of these children, and the long-term commitment and highly skilled workforce required to support them.
- For the child protection system to be effective, it must first be clear about the scope of its responsibilities and the longevity of its commitment to children.

- The health system must recognize the fundamental part it plays in assisting children from vulnerable families with their health concerns. Antenatal and post-natal care for mothers and infants is especially important.

The Committee reports on the recommendations it has made about each of these issues. The Committee's recommendations often result in the provision of information that seeks to demonstrate that the agency has existing policies and programs that address the issues it has raised.

It is the Committee's view that agencies would do better to gather and provide evidence to demonstrate how the implementation of their good policies and practices have improved outcomes for children. That is, agencies should focus not so much on perfecting policies as on making children's lives better.

Special report – Aboriginal child deaths

The death rate for Aboriginal children has not declined in the past ten years in South Australia. Aboriginal children are still three times more likely to die than non-Aboriginal children.

The complexities common to the lives of Aboriginal children are considered in this special report. For the past decade, the Committee has recognised these complexities and addressed them in its recommendations, and its reviews continue to identify failures in service delivery to Aboriginal children and their families. The Committee comments on a series of cases in which children died or were seriously injured. It is the Committee's view that scores of notifications, beginning when a child is very young, should be predictive enough to identify the need for timely attention.

Child deaths in South Australia

There has been a decline in the rate of child deaths in South Australia between 2005 and 2014, as evidenced by the Committee's monitoring of these deaths. In the same time period there were significant declines in the rate of death of young people aged 15 to 17 years in transport incidents, and the sudden unexpected deaths of infants. The fall in rates of death of these two groups of children is likely to be responsible for the fall in all child deaths. It is the Committee's view that there is still a significant capacity for efforts to prevent the number of suicide deaths, the deaths of infants in unsafe sleeping environments, and the drowning deaths of children in family swimming pools.

The Committee's data analysis demonstrates a strong association between disadvantage and child death. Socioeconomic disadvantage is not a choice that children make.

For children to be safe, and for their wellbeing to be assured, both community and government must work together to achieve the systemic changes that are necessary to support them. The Committee's recommendations can provide guidance about those changes.

Future directions

The statutory responsibility of the Committee is to review cases of child death and serious injury with a view to identifying systemic change that may prevent future deaths or serious injury and to make and monitor the implementation of its recommendations. To fulfil these obligations in 2015-16 the Committee will:

- Monitor service delivery to children who have been under the Guardianship of the Minister whose infants have died.
- Seek further evidence from health, education, housing and children protection agencies about implementation of recommendations concerning their recognition of and response to the neglect of children.
- Submit reviews to the Minister that address policy and practice change in Families SA.
- Continue to review, monitor and advocate for changes that have the potential to improve children's access to health services and the pro-active delivery of services to children with disability.

Improvements in service delivery to children will continue to be recommended by the Committee.

Death and serious injury to children in South Australia may be lessened if service agencies implement the Committee's recommendations.

Special Report

Special Report: Aboriginal child deaths

Aboriginal child deaths 2005-14

The Child Death and Serious Injury Review Committee (CDSIRC) has kept comprehensive statistical information on the deaths of children in South Australia, since it was established in 2005 under the Children's Protection Act 1993.

In the ensuing decade, 1,127 children died in South Australia.

Although Aboriginal children make up only 3.5% of the population of South Australian children aged 0-17 years, they accounted for 11.6% of the deaths that occurred from 2005 to 2014, and were 3.6 times more likely to die than non-Aboriginal children.

Although the overall death rate declined by 2% on average per year for all South Australian children during this period, it did not decline for Aboriginal children.

Of the 131 Aboriginal children who died between 2005-2014:

- 57.3% were male
- 56.5% were under one year of age, and 16.8% were aged 15-17
- Over half died as a result of illness and disease, and a further 30% died as a result of external causes, including transport crashes and suicide
- 61% had had contact with Families SA
- 68.7% came from the two highest (of five) classifications of socio-economic disadvantage
- 19% had their usual residence in another State
- Of those resident in South Australia, 36.8% lived in a major city, 40.6% lived in regional areas, and 22.6% in remote/very remote locations.

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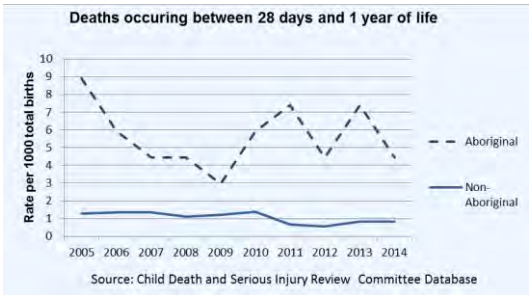
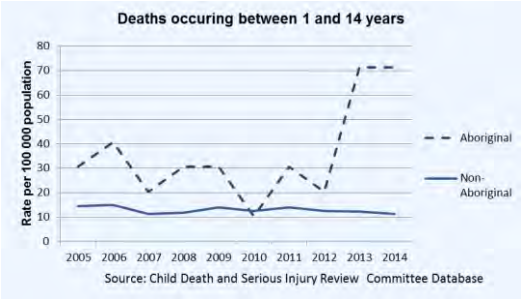
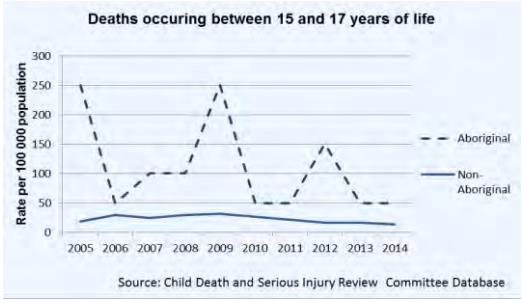
Deaths occurring by age and Aboriginality







Indicators of disadvantage

The disadvantages experienced by many Aboriginal children continue to be reflected in their health outcomes, educational experiences, level of contact with the child protection system, and their over-representation in the juvenile justice system.

In reading the following statistics, it should be kept in mind that Aboriginal children make up only 3.5% of the population of South Australian children aged 0-17 years.

Health

- Information from the Pregnancy Outcome Unit for 2012[1], showed that:
- The perinatal mortality rate for births to Aboriginal women was 16.4 per 1,000 births compared with 8.7 per 1,000 births for births to non-Aboriginal women.
- The proportion of pre-term births (<37 weeks gestation), was 17.5% among babies of Aboriginal women, compared with 9.2% of non-Aboriginal women.

[1] *Scheil W, Scott J, Catcheside B, Sage L, Kennare R. Pregnancy Outcome in South Australia 2012. Adelaide: Pregnancy Outcome Unit, SA Health, Government of South Australia, 2014.*

- The proportion of low birth-weight babies (<2,500g) was 14.8% for Aboriginal women and 6.9% for non-Aboriginal women.
- Of women giving birth, 18% were Aboriginal teenagers, compared with 3.3% of non-Aboriginal teenagers.
- 49% of Aboriginal women attended antenatal care within the first 14 weeks of pregnancy (of those for whom week of gestation was recorded at first antenatal visit), compared with 79% of non-Aboriginal women.
- At the first antenatal visit, 49% of Aboriginal women reported that they smoked, compared with 10.7% of non-Aboriginal women.

Education

NAPLAN results[2]

The following NAPLAN results show the percentage of students who scored at or above the minimum standard in South Australia. The results of Aboriginal children are consistently lower than those of non-Aboriginal children, but most notable is the difference in scores for children living in very remote areas.

The results for reading and numeracy, for Aboriginal and non-Aboriginal children in years 3,5,7 and 9 were examined.

The average result for Aboriginal children across the State, was 21.4% lower than for non-Aboriginal children.

However, in very remote areas, the average result for Aboriginal children was 56.25% lower than for non-Aboriginal children.

Attendance rates[3]

Attendance rates for Semester 1 from 2011 to 2014 for students from Reception to Year 12, show that rates of attendance are, on average, 11.8% lower per annum for Aboriginal students.

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[2] *Australian Curriculum Assessment & Reporting Authority. National Assessment Program. Literacy and Numeracy. National Report for 2014.*
[3] *Data Management & Information Systems, Department for Education and Child Development, South Australia.*

Apparent Retention Rates of Secondary School Students[4]

The rate of retention of students in years 8-12, showed a gap of 10% between the rates of Aboriginal and all students in 2014.

Child protection

Care and protection orders

In 2014, 29.1% of the children aged 0-17 years on care and protection orders (including custody, guardianship or supervision), were Aboriginal.[5]

The rate of Aboriginal children and young people aged 0-17 years on care and protection orders, was 50.7 per 1,000, compared to 5.7 for non-Aboriginal children and young people.[6]

Substantiated notifications

The rate of substantiated notifications for Aboriginal children was 43.4 per 1000 children, while the rate for non-Aboriginal children was 4.1 per 1000 children.

Out of home care

Of the 2,631 children aged 0-17 in Out of Home Care at 30 June 2014, 29.7% were Aboriginal children.[7]

Under Guardianship of the Minister

At 30 June 2014, there were 2,577 children and young people under the guardianship of the Minister, of whom 29.6% were Aboriginal.[8]

Juvenile justice

While young Aboriginal people comprise only 4% of the State's population of 10-17 year olds, they account for 46% of young people in detention.[9]

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[4] *Data Management & Information Systems, Department for Education and Child Development, South Australia.*
[5] *Office of the Guardian for Children and Young People. Aboriginal Young People in State Care in South Australia. June 2014.*
[6] *Office of the Guardian for Children and Young People. Aboriginal Young People in State Care in South Australia. June 2014.*
[7] *AIHW. Child Protection Australia 2013-14.*
[8] *Office of the Guardian for Children and Young People. Young People in State Care and Custody in South Australia. June 2014.*
[9] *The Productivity Commission. Report of Government Services 2015. Tables 16A9, 16A10.*

Young Aboriginal people were 12.5 times more likely to be involved with the juvenile justice system (that is, under juvenile justice supervision, in juvenile detention, or under community supervision) than non-Aboriginal people of the same age, and 19.7 times more likely to be in detention.[10]

Child death – commonalities, complexities and system response

When the Committee reviewed the case notes of many of the Aboriginal children who died or had been seriously injured during the past decade, a picture began to form that typified the experiences of many of these children and their families.

The context is often one of disadvantage, arising in part, from the circumstances of their parents' lives and histories.

The lives and circumstances of three of the children who died have been examined for the purposes of this report. All of the children had siblings who experienced the same circumstances. Two children died in transport crashes, and one of natural causes.

All of the children were born into families whose situations were very complex. Many factors contributed to this complexity, including the legacy of the State's treatment of Aboriginal families, parents traumatised by their own experiences, intergenerational poverty and despair, suspicion of human service agencies, health problems - including mental health issues, the effects of alcohol and drug abuse, domestic violence, and relatives overextended as carers. These factors have resulted in traumatic lives for many children, and they are challenging for families and service providers alike.

Despite these complexities, when children are experiencing frequent trauma, abuse and neglect, unsafe environments and abandonment at very young ages, it is incumbent upon the community in which they live to ensure their safety and developmental wellbeing. The agencies that bear those responsibilities on behalf of the State/community are accountable to the State/community for the discharge of that duty.

Under the Children's Protection Act 1993,[11] each one of these children (and their siblings) was, throughout life, by every aspect of the definition, 'a child at risk'.

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[10] The South Australian Council of Social Services, *Justice or an Unjust System? Aboriginal over-representation in South Australia's juvenile justice system. April 2015.*
[11] *Children's Protection Act 1993. (SA)* Part 1, 6 Interpretation.

Study 1

Traumatised by witnessing and experiencing violence within the family, this child and his siblings were the subject of notifications and other contacts with Families SA (FSA) or its precursor departments from very early in his life on over 50 occasions for requests for assistance, abuse, witnessing violence, neglect and abandonment.

Sexually abused as a child, suicidal from a young age, and dead before adulthood, in spite of scores of notifications.

It is hard to accept the responsible agency's Review Report which stated that his death was not foreseeable, nor preventable by the responsible services.

Study 2

This child had been in the care of various family members throughout his life.

Agencies noted that this child lived in a 'family in crisis', and within an 'unsafe environment'. He and his siblings were not consistently cared for, supported, supervised nor protected from harm, in spite of over 50 notifications and other contacts with the child protection system.

His siblings were finally placed under the Guardianship of the Minister, and while their care is now more consistent and protective, their emotional and behavioural responses continue to reflect their years of deprivation.

Study 3

By the time this child was born, none of his oldest siblings were still living with their mother, all having been the subject of child protection concerns. He was one of the family's younger children and died as a result of illness. His death brought the experiences of his youngest siblings to the attention of the Child Death and Serious Injury Review Committee.

On over 50 occasions there were notifications and other contacts with the child protection system regarding this family. Finally, after some years, three final notifications resulted in the younger children being removed from the family and placed in care.

Commonalities of studies

These three children grew up in different families, places and communities, but the commonalities in their circumstances are striking. These aspects of the children's and their siblings' experiences, are listed below.

Study 1	Study 2	Study 3
Domestic violence	Domestic violence	Domestic violence
Neglect/lack Supervision	Neglect/lack Supervision	Neglect/lack Supervision
Mother couldn't control	Mother couldn't control	Mother couldn't control
Abuse	Abuse	Abuse
Domestic squalor	Domestic squalor	Domestic squalor
Unkempt	Unkempt	Unkempt
Lack of food in house	Lack of food in house	Lack of food in house
Unhappy with Mother drinking	Unhappy with Mother	Unhappy in parents' care
Distressed in father's care	Distressed in mother's care	Afraid of father
Alleged sexual abuse	Sexually abused	Sexually abused
Suicidal	Suicidal	All children 'At Risk Infants' at birth but placed with parents
Roaming	Roaming at night, alone	
Drugs/alcohol	Glue/aerosol sniffing/alcohol	
Risky behaviours	Risky behaviours	Risky behaviours
Abandoned by mother -physically	Abandoned by mother -physically/emotionally	Abandoned by mother -physically/emotionally
Children left with others -known and unknown	Children left with others -known and unknown	Children left with others -known and unknown
Sibling removed from mother	Sibling removed from mother	Siblings removed from parents
Asthmatic	Asthmatic	
Low school attendance	Low school attendance	Delayed learning
Numerous carers/homeless	Numerous carers	Numerous carers
Found places to stay	Found places to stay	
Attended Youth Court	Minor offences committed	
Under Guardianship	Siblings under Guardianship	Siblings under Guardianship

These commonalities illustrate the experiences of children who were not provided with the care, protection and nurture necessary for them to thrive.

They are a result, in part, of the complexities of parents' lives – the factors that contributed to their inability to cope and parent their children adequately.

There were also some significant commonalities between the experiences and complexities of the children's mothers' lives.

Complexities – contributing factors

As mentioned, the general level of disadvantage and trauma experienced by generations of Aboriginal families, their distrust of human service agencies, and the burden of chronic health problems - including physical and mental health issues, and the effects of alcohol and drug abuse - have affected parents' capacity to provide adequately for themselves and their families.

The mothers of the children in all three studies: had suffered as a result of domestic violence; were sexually abused as children; engaged in alcohol and/or drug use at a level detrimental to their children; had health/mental health problems; and struggled to stay in contact with services designated to assist them. Furthermore, many of the parents of these children who became known to the child protection system, experienced similar childhoods themselves.

In trying to understand the parents' experiences (including meeting the demands of systems trying to assist them, and protect the wellbeing of children), it is clear that the desire of parents to care for their children, and their capacity to do so, are sometimes two different things.

A striking aspect of this issue is children's awareness of the situations in which they find themselves. There are many records expressing children's insightful observations and feelings about their lives.

Those observations and feelings were not always given sufficient consideration by agency staff making decisions about them. All children have the right to give their opinion, and for adults to listen and take it seriously.[12]

[12] *UN Convention on the Rights of the Child, Article 12*

The response of the child protection system

Systems and services concerned with child protection and safety have to be very comprehensive and committed in order to respond effectively to the complexity of the cases they encounter.

It is hoped that the lives of many children are improved as a result of service endeavours.

Cases in which children die or suffer serious injury are reviewed by the Child Death and Serious Injury Review Committee (CDSIRC) to determine if 'there are grounds to believe that the death or serious injury might have been prevented by some kind of systemic change'.[13]

By its review the Committee seeks to:

- identify legislative or administrative means of preventing similar cases of death or serious injury in the future;
- make, and monitor the implementation of, recommendations for avoiding preventable child death or serious injury.

In each of the three studies above, there were a significant number of notifications to Families SA or its precursor departments regarding those families. Even so, the children still died, and in some cases, their siblings were injured necessitating removal from their families.

The files and reports that chronicle agencies' contact with the families prior to critical events, illustrate the assessments that were made, the actions that were taken by agencies, and the missed opportunities for systems to protect the children.

In all three of the cases discussed, it was clear early in the children's lives that they were suffering trauma, they were experiencing multiple forms of abuse, they were unsafe, and they were at risk of further harm.

In all three studies, many individuals alerted the system that this was the case. Prior to the critical events of death or injury, the system's responses did not match the complexity of these cases. The cost of an ineffective response is too high for the children who die or are injured.

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[13] *Children's Protection Act 1993* (SA) 52S

The system's heightened response after a critical incident is notable. Case files record the concerted effort that is made with the families of those who have died or been injured. It must be supposed that some of this effort made earlier might have spared the children and their families these tragic outcomes.

Agencies charged with the responsibility of child protection are accountable to the Government and the community for the discharge of that duty. This responsibility extends to all agencies, which, as part of their service delivery, come into contact with children. That duty always remains with the agency, even when services are contracted out.

Too often, in circumstances where children are suffering, an agency determination of 'RPI' (Resources Prevent Investigation) or 'NOC' (Notifier Only Concern) has been recorded, or a decision made to close the case before a child's safety is assured. Unfortunately, for these children, there is no other 'backstop'.

The community should ask whether these children are also victims of system neglect.

The Committee has considered the stories of these and many other children who have died as a result of illness and disease, prematurity, unsafe sleeping conditions, accidents and suicide. Its many recommendations to agencies and systems have addressed key factors that resulted in a child's death or serious injury – including the gaps and omissions in agencies' care and protection of the children for whom they are responsible.

The Committee's recommendations

The Committee's reviews of some of the 1,127 deaths and cases of serious injury of children in South Australia, have resulted in many recommendations to agencies and systems involved in providing services to children. While the rate of death among children decreased by 2% on average in the decade between 2005 and 2014, there is, necessarily, a great deal of repetition in the Committee's recommendations, even after a decade.

In relation to the death of Aboriginal children, the Committee has undertaken reviews that have considered the deaths of infants, children with disabilities and chronic illnesses, young people who have suicided, and those who have died in transport crashes. These children may have had contact with various systems including child protection, health, education, housing, and the juvenile justice system.

The Committee has made recommendations about the issues arising from these reviews, many of which address those noted in the studies above. These recommendations relate to:

- recruitment and training of service staff
- ensuring the competence of staff to undertake complex cases within sound management and supervisory structures
- undertaking long term, proactive case management where children are suffering neglect, or are diagnosed with medical conditions
- understanding relevant statutory powers, and developing appropriate policies and procedures to inform practice
- ensuring cultural equality and appropriateness in approach and action – particularly in rural and remote regions
- sharing information with agencies involved with the same children and their families.

These recommendations are all set out in the Appendix to this Special Report.

Agencies' responses to recommendations

The Committee is concerned that agencies to which recommendations are made - while clearly committed to the wellbeing of children, and to the promulgation of policies and practices that will improve child safety - do not appear to appreciate the necessity to implement the recommendations as a matter of some urgency.

In the three studies of child death and injury outlined above, one of the commonalities was the very high number of notifications and other contacts made regarding the families, from the time of the children's infancy.

The Committee sees the continuation of notifications regarding a child and its family, over a period of time, as an alert that comprehensive attention is needed.

It is clear from reading the stories of the children who have died, that the need for effective assistance to the children and their families was required very early in the children's lives.

In an effort to elicit better responses from agencies, the Committee has made specific requests for information and/or action, and did so regarding this issue recently.

The Committee asked the agency, whether it is reviewing similar families with a view to taking action if children are in comparable circumstances. Has the agency begun to use its database to pre-empt checks on children who are persistently at risk? In respect of these children, is the agency reviewing them proactively or waiting for the next/worst notification?

In response, the agency advised, in part, that it is involved with a research partner looking at ways to 'better predict cases of child neglect or abuse', and 'explore cumulative harm in the child protection population'. It advises that 'the research is not due for completion until 2016-17, and it is anticipated the research will be used to develop a predictive model to identify children earlier who may experience chronic neglect'.

The Committee maintains that scores of notifications since infancy, should be predictive enough to identify that these children require timely attention.

The Committee notes that the rate of Aboriginal child deaths has not declined in the past ten years, and its reviews continue to identify failures in service delivery to Aboriginal children and their families.

Clearly, there is still a lot that must be done.

The only outcome the Committee foresees if agencies do not address these issues, and fail to give due consideration to the recommendations made in the aftermath of child deaths, is the ongoing trauma, neglect and continued loss of Aboriginal children in our community.

Special Report Appendix

Recommendations about the safety and wellbeing of Aboriginal children

Cultural equality and appropriateness

Apply the same standard of care for Aboriginal children as for non-Aboriginal children.

- Intervene in culturally appropriate ways which ensure that the consideration of risk and safety issues for Aboriginal children is no different to that of non-Aboriginal children.
- Provide the same level of access to services to all children, including those who live on the APY Lands, in relation to education, health (antenatal and post natal care, immunisation, medical treatment, health promotion, prevention and treatment of chronic ear infection and mental health), and welfare services sufficient to provide them with the skills and knowledge that they need to live in their communities.
- Ensure the education of all children who live on the APY Lands, and address non-attendance at school.
- Demonstrate how Aboriginal families from rural and remote areas of the State will be assisted with appropriate grief counselling, support and transport back to their communities following the death of an infant in Adelaide.

Workforce Recruitment and Training

- Build workforce capacity to provide culturally responsive services.
- Have appropriate training programs in place for new workers, supervisors and senior practitioners based on a clear set of competency standards which must be met, and that these competencies are aligned with the degree of complexity in the cases they are given to manage/supervise.

Have effective employment strategies in place to support the employment, supervision and professional development of Aboriginal workers.

Practice competence to undertake complex cases, sound management and supervision

- Review and amend their assessment and intervention procedures and practices in cases where children present with features of neglect.
- Sight the child in its home environment (including sleeping arrangements for infants).
- Change its response to Tier 3 notifications about Aboriginal children such that closing a case on the basis of non-response to a letter, is not an acceptable outcome.
- Undertake long term and proactive case management that includes the assessment of carers, and the recognition and assessment of risk as it relates to neglect.
- Take responsibility for implementation of the child-centred case management or care plan, which may have multi-agency involvement, but is coordinated by a case manager from the lead agency – and implement until such time as a decision is made that the child's needs no longer require case/care management.
- Do not withdraw services or close a case until there is a case plan in place which details responsibility for case management and service provision.
- Ensure the parents'/carers' awareness of public health and safety campaigns.

Statutory powers and developing appropriate policies and procedures to inform practice

- Review the use of their statutory powers under their respective Acts and ensure the formal and timely assessment of children at risk.
- Have policies in place which ensure the appropriate management and supervision of Aboriginal cultural consultants who are required to manage complex and high risk cases.
- Have policies in place to ensure that complex cases are not allocated to workers with less than the predetermined level of competency.

Information sharing with agencies involved with the same cases and issues

- Share information about the child with other agencies in a timely manner.
- Act immediately to integrate the information it already holds about Aboriginal women, and ante and postnatal services, to design and deliver an integrated service that will have a direct impact on Aboriginal infant mortality.
- Establish a planned process for children under guardianship to assess, monitor and respond to the therapeutic and developmental needs of each child, and so ensure that their learning, socialisation, relationship, health and emotional needs are met throughout the period of guardianship.

Section One

Improving the safety and wellbeing of South Australia's children

S52S – Functions of the Committee

(1) The Committee's principal functions are –

(a) to review cases in which children die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future; and

(b) to make, and monitor the implementation of, recommendations for avoiding preventable death or serious injury.

Children's Protection Act 1993

1. Improving the safety and wellbeing of South Australia's children

Through its reviews of child deaths and serious injury over the last ten years, the Child Death and Serious Injury Review Committee has developed an evidence base that allows it to identify key systemic issues in the provision of services to children.

In this section of the report, the key issues that have been the focus of the Committee's work in 2014-15 are presented. These include children under Guardianship of the Minister; children with disability; young people at risk of suicide; neglect, and the ways in which child protection and health systems respond to children's needs.

In relation to each issue, the Committee provides the evidence it has about that issue, the actions it has taken to review the issue, the outcomes of this action, and future directions it will take to effect systemic change to improve the safety and wellbeing of children in South Australia.

1.1. Responsive care for children under the Guardianship of the Minister

Children under the Guardianship of the Minister are entitled to responsive care that provides them with the best opportunity to become adults who can participate in a meaningful way in society, and effectively parent their own children.

In some situations, to achieve this they need sustained support beyond 18 years of age from practitioners who understand and can respond to their needs.

Evidence

The review looked at the lives of nine young parents with a history of guardianship whose infants died. The key features in the lives of these young parents included the following circumstances:

- All had experienced physical, emotional and sexual abuse over an extended period of time, and this continued to have an impact on their lives. These

experiences appeared to result in a lack of trust in adults responsible for providing care.

- All but one had had frequent changes in placement and school location.
- All of the young female parents experienced depression and were regularly using drugs and alcohol throughout the period of their guardianship and adult lives.
- Many of these young people had their first child early in life, some while still under guardianship.
- Three of the nine young parents were Aboriginal.

The infants of these young parents died primarily as a result of their premature births. Of the other twelve children of these young parents, most were placed in alternative care or deceased.

Issues

Multiple services including child protection, housing, health and education services were provided at various times to the young people during guardianship, and after transition from guardianship. These services were not ultimately effective in preventing the circumstances that led to the death of some of their infants and the serious injuries sustained by their other children.

In the Committee's view, the State can prepare children and young people in care for parenting by:

- Keeping changes of placement, worker, community and school to a minimum throughout the period of a young person's guardianship.
- Maintaining a level of commitment to therapeutic intervention, and providing therapeutic living environments that will assist children and young people living with high levels of trauma, across the span of their years in guardianship.
- Recognizing the importance of a child or young person's desire to remain connected with their biological family, and managing this connection such that it is a positive experience for that child or young person.
- Giving responsive and timely support when a young person is pregnant or parenting young children. Young parents under guardianship should receive a quality of care as good as young parents in the care of their families.

- Recognizing the risk that a young person under guardianship may replicate their own life experience when they become a parent. Families SA must carefully consider its role so that when young people under guardianship have a child, the authority that was put in place to provide guardianship and support does not appear to be a threatening force which judges their ability to parent.
- Actively engaging with children and young people across the period of guardianship and beyond. In 'normal' family life it would be unusual to sever connection with young people at the age of 18 years. Their 18th birthday is the first stage of the transition to adulthood.

Actions

The Committee has submitted numerous reviews in the past with clear recommendations about transition planning and implementation, preparation for parenthood, extended support after the age of 18, and interventions designed to develop confidence and preparedness for independence.

The Committee has asked the following questions of Families SA about present practice, current data collection and service responses, and the outcomes for young people transitioning to independence.

Of the total number of young people (aged 14 to 17 years) under the guardianship of the Minister in the last two years:

- How many young people have current transition plans?
- How many young people have lost contact with Families SA?
- How many young people have inactive management?
- How many young people are not having a face to face meeting with their caseworker once a month for 10 months of the year?
- How many young people are there where the Department does not know their current location?
- How many young people have their own children? How many children do they have? How many of those young people have retained their own caseworker?

Of the total number of young people under guardianship of the Minister who turned 18 in the last two years:

- How many young people transitioned out of care?

- How many young people had a transition plan that was extended past the age of 18 years?

Future directions

The Committee remains concerned that information of this sort should be available for policy development and operational accountability. The outcomes for children and young people under guardianship should be core business for Families SA. The Committee will maintain an active watch in relation to the deaths of children in these circumstances, and as at 30 June 2015 still awaits a response to these questions.

1.2. Pro-active services for children with disability

Children with disability will experience improvement in quality and length of life when there is a pro-active and holistic plan for service provision, and when services are well coordinated and address not just the child's needs but the needs of their family and siblings.

Evidence

Approximately one third of children aged 1 to 17 years who die in South Australia, live with a disability for more than six months of their lives. The main causes of these disabilities are neurodegenerative disorders, genetic disorders or birth defects.

The Committee's reviews have shown that these children often had high level, complex needs. Their life opportunities and the quality of their lives within their family, or with carers, was significantly compromised by poorly coordinated and random service delivery. To maximise their potential and to prolong life as long as possible, they required integrated, responsive, and long-term service involvement.

Issues

The Committee found that high quality, well-coordinated systemic responses supported children and their carers in ways that improved the quality of the child's life, and the length of their life. The Committee found that there was an absolute connection between the care of a child with disabilities and the effective support of their carers, whether family, foster carers or paid care.

The Committee's reviews in 2014-15 considered the deaths of five children with disabilities. These reviews have highlighted how poor systemic responses to the needs of children and their families can result in:

- The decline of the mental and physical health of carers, and in some cases of the siblings of the child.
- Significant impact on financial and socioeconomic circumstances of the carer.
- Involvement of the child protection system and the relinquishment of care, either voluntarily or involuntarily.
- An imbalance in the care available as the child ages, often resulting in the reduction of support such as respite care, despite the child's increasingly complex requirements.

Actions

The Committee made recommendations to address these issues including:

- The careful assessment of children's needs that is long term, and accounts for the likely increasing needs of children with disability as they grow older.
- The attention that must be paid to supporting children and their carers in the short-term through access to respite, expert and well-coordinated assistance that addresses the child's needs (including the need for assistance with challenging behavior), and the provision of essential requirements such as special foods, formulas and nappies.

In its recommendations to the Department for Education and Children's Services, and to Disability SA, the Committee has advocated for an approach like 'Team around the Child'.[14] This approach seeks to build a systemic response to a child's needs through holistic, multi-disciplinary assessment, coordinated and well managed service provision, and the inclusion of both the child and the family in service planning.

As part of its submission to the Royal Commission into Child Protection Systems, the Committee highlighted the need for well-coordinated service delivery to children with disability and pointed to the need for changes to *the Act* to acknowledge that some parents, despite their efforts, must relinquish the care of their child to the State in order for the child to receive the services he or she needs.

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[14] *http://www.teamaroundthechild.com/tacmodel/the-tac-approach.html Accessed October 2015*

The Committee is aware that the provision of support to children with disability and their families is changing significantly with the roll out of the National Disability Insurance Scheme (NDIS). It has met and corresponded with the State Ministers for Education and Child Development, and Disability, and with representatives from the National Disability Insurance Agency about its concerns regarding this scheme.

In its most recently submitted reviews, the Committee has asked the Minister for Education and Child Development to request that the Minister for Disability and the NDIA address the following questions:

- How will the NDIA ensure better coordination of services bearing in mind that there will likely be a number of service providers involved and that they will likely be from the non-government sector?
- How will the NDIA ensure that service provision is such that quality of care within the family can be maintained above the threshold of involvement of child protection services?
- How will the NDIA support the parents and other siblings (eg, with respite services) and liaise with the relevant state-based services (eg, schools)?
- How will the NDIA demonstrate an appreciation of the changing needs of the child client as he/she grows older?

The Committee has asked the Minister to liaise with the NDIA and support the Committee's request for a memorandum of understanding between the NDIA and the Committee. This MOU would allow the Committee access to information about service provision to a child who has died. This information is vital as it forms the basis of the Committee's reviews and without it, the Committee will be unable to fulfil its statutory obligations.

Future directions

The Committee's recommendations have focussed on the provision of services that will achieve both quality of life and longevity for children with disability. It is especially concerned about those from the most vulnerable families where the capacity to provide care is constrained by socioeconomic circumstances, the mental and physical health of parents or carers, and sometimes by the disabilities of the parents themselves.

Through its reviews in 2015-16, the Committee will:

- Monitor how the NDIA is impacting on service provision to children with disability.

- Determine if educational opportunities are maintained despite the complexity of managing children with disability in mainstream education.
- Monitor the ways in which the needs of children with disability are addressed and the adequacy of support to those involved in the care of children with disability.
- Improve its understanding of the role of the Guardian for Children and Young People in supporting children with disability.

1.3. Suicide prevention and young people

Evidence

Since 2005, the number of deaths attributed to suicide each year has fluctuated from one death in 2007 to seven deaths in 2013. The average number of such deaths per year has been four. In South Australia, more 15-17 year olds die from natural causes and transport crashes than from suicide each year.

Issues

Through the careful examination of the life histories of young people who have suicided, the Committee can inform systemic improvements to the planning of suicide prevention responses. The Committee's 2013-14 Annual Report summarised its suicide review.[15] In that review the Committee identified three groups of young people. Within each group the young people had similar life histories, and for each group the Committee proposed different opportunities for intervention and prevention.

Effective prevention and intervention efforts for young people at risk of suicide must cover a broad spectrum of initiatives.

Actions

The Committee has shared its findings about these different groups and prevention opportunities through presentations to policy-makers, researchers and practitioners, and a presentation at the 2014 Child Death Review Conference. The Committee

[15] *CDSIRC Annual Report 2013-14 Sections 1.1.12 (p 11) and 2.2 (p 24)* http://www.cdsirc.sa.gov.au/files/links/CDSIRCAnnualReport2014.pdf

flagged its findings in a written submission to the National Children's Commissioner's Inquiry into Suicide, and through participation in a round table for that Inquiry.[16]

The Committee submitted a summary of the suicide review to the Minister for Education and Child Development in June 2015. The Committee recommended that the Minister:

1. Distribute the Committee's report to all relevant government and non-government agencies which provide services to young people.
2. Write to the Minister for Health and request that the SA Health State Suicide Prevention Plan be considered in the light of this report to ensure that it includes strategies and actions that address the needs of each group of young people.
3. Demonstrate the ways in which every effort is being taken to ensure that Aboriginal children are receiving a level of health, education and welfare services sufficient to provide them with the skills and knowledge that they need to live in their communities.

In 2014 the State Coroner also made recommendations about young people and suicide following inquests into the suicide deaths of two young people.[17] The Coroner's recommendations focussed on improvements to the Child and Adolescent Mental Health System (CAMHS). The Committee's review also identified the importance of a strong and proactive mental health service for young people at risk of suicide.

Six months after the release of the Coroner's report, the Committee sought information from CAMHS about the restructure of its service, particularly with regard to the assessment of high risk young people and the strengthening of a cohesive multi-disciplinary approach to its work with them. Based on information provided by CAMHS, progress has been made through the development of guidelines and policies that address these issues.

Of equal concern with regard to the restructure of CAMHS, is the transition of services for 16 and 17 year olds to the State's adult mental health service, especially for

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[16] *National Children's Commissioner Children's Rights Report 2014. Australian Human Right Commission, Sydney https://www.humanrights.gov.au/sites/default/files/document/publication/Children%27s%20Rights%20Report%202014_2.pdf*

[17] *http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/584/MUNDY%20Michaela%20Jayne.pdf*
http://www.courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/593/HUGO-HORSMAN%20Jason%20William.pdf

vulnerable young people such as those under Guardianship, and those young people at risk of suicide who are disengaged from school, family and service agencies.

Future directions

In the next 12 months the Committee will:

- Ascertain from SA Health how it is restructuring the adult mental health service to cater for these young people; how it is training staff to provide an appropriate service; and how they are monitoring the effect of this change on the health and wellbeing of young people using the service.
- Request an update from CAMHS about progress with its restructure.
- Work with the Coroner's office to effect changes that will assist in further clarifying the circumstances of deaths by suicide.
- Seek a progress report from the Minister about the implementation of its recommendations.

1.4. Guidelines for infant safe sleeping

Each year a number of infants die suddenly and unexpectedly, and although the cause of death may be undetermined, there will be risk factors in the infant's sleeping environment that may have contributed to that death. Risk factors include the infant co-sleeping with parents, the presence of pillows, or the use of a cot that does not meet Australian standards.

In 2014-15 the Committee participated in the review of SA Health's *South Australian Safe Infant Sleeping Standards*. This review was undertaken to ensure that the guidelines continued to reflect best practice standards for infant safe sleeping. These revised guidelines were due for release by SA Health in September 2015.

In 2015-16, the Committee will continue to liaise with Kidsafe SA, SIDS and Kids SA, and the Epidemiology Unit of SA Health about prevention issues arising from its reviews of infant deaths.

1.5. Systemic responses to neglect

Children must a central consideration for each agency. It is important that they are seen, and that their voices are heard.

Evidence

While neglect as the sole cause of death is relatively rare (over the ten year reporting period from 2005-14, six deaths have been directly attributed to neglect), numerous reviews into a range of deaths and serious injuries have identified neglect as a key factor in the lives, and deaths, of vulnerable children.

In a number of previous reviews, the Committee has drawn attention to the failures of service providers to recognise signs of neglect and to act on them.

Issues

The Committee is strongly of the view that neglect is too often overlooked as a real and substantial risk factor in the lives of vulnerable children. The 2012 review of six seriously injured children highlighted that:

- The education system needs to improve its response to truancy and chronic school non-attendance.
- Housing SA and SA Health need to improve the ways in which they identify children at risk of neglect.
- The child protection system must build its capacity to recognise and respond to cases of neglect.

In each case, the key factor that will determine an agency's response to the issue of neglect rests with its commitment to the wellbeing of children, and to the implementation of policies and practices that keep children safe.

Actions

In its 2012 review of six seriously injured children, the Committee made a series of recommendations addressed to four different agencies about how those agencies could better identify and respond to issues of neglect. These four agencies were Families SA, Education, Housing SA and SA Health.

The Committee also addressed the issue of interagency communication, and the importance of recognising the phenomenon of closure, where a family deliberately shuts itself away from contact with the outside world and children are sequestered.

In the Committee's view, the only way to assess whether neglect is occurring, as a first step, is to sight the child in their home environment.

In 2013 each agency was asked how it was responding to, and implementing, the Committee's recommendations.

A number of those responses were, in the Committee's view, less than satisfactory. In 2014 the Committee made similar enquiries of the agencies. In that year the Minister provided the Committee with an update on the agencies' responses. Each agency's response was essentially the same (sometimes even word-for-word) as its response one year earlier. Through the Minister, the Committee has again requested further information from each agency. As of 30 June 2015, there has been no response.

It is of concern to the Committee that these agencies, whilst expressing a no doubt genuine commitment to the wellbeing of children, and to the implementation of policies and practices that will keep children safe, do not seem to appreciate the necessity to address and implement the Committee's recommendations in a timely way.

In addition to making and monitoring recommendations about neglect, the Committee has contributed to SA Health's guidelines on severe domestic squalor. The Committee has sought to ensure that identifying the presence of children, and sighting them, is one of the first tasks to be attended to in response to severe domestic squalor. This work has been done through its representation on the South Australian Severe Domestic Squalor Interagency Group.

Future directions

Children must be central in service provision to families where they are at risk, whatever the basis of the risk. Recommendations about these issues will be the focus of the Committee's current review into the death of Chloe Valentine and another review of a young, seriously injured child.

In 2015-16 the Committee will:

- Seek clarification from the Minister about the Government's commitment to the implementation of the Committee's 2012 recommendations, arising from the review of six seriously injured children about neglect.
- Make and monitor recommendations which highlight the systemic change necessary to ensure that the policies and practices of agencies delivering services to children, promote actions that recognise the impact of neglect on their safety and wellbeing.

1.6. The child protection system's response to children

The child protection system is a key system with responsibility for the safety of children. Its policies and practices must reflect an understanding of what protecting children means, as well as a long-term commitment to children.

Evidence

In any given year, approximately one quarter of children who have died, or their families, had had contact with the child protection system in the three years before their death.

Issues

In its 2013-14 Annual Report, the Committee identified key issues that needed to be addressed by Families SA as part of the re-design of its services. These issues included: staff training; support and supervision; case management; and, services in rural and remote areas.

Further issues about the child protection system were raised in the review of six seriously injured children concerning the management of child protection emergencies, the support of children who have experienced trauma, and the scope and management of residential care agreements.

Since that time, the child protection system has been the focus of inquiries such as the Royal Commission into Child Protection Systems, and the coronial inquest into the death of Chloe Valentine. The Committee broadly supports the Coroner's recommendations about the child protection system arising from that inquest. It considered many of them to be in keeping with previous recommendations it has made to address similar issues.

The Committee is heartened by the similar views expressed by such inquiries and feels confident that each of them will provide opportunities for further improvement to child protection services.

Actions

In January 2015, the Committee made a submission to the Royal Commission. In that submission, the Committee's views about changes to Families SA policies and practice

were consistent with those expressed in its 2013-14 Annual Report. The changes outlined in that submission reiterated the importance of:

- Responding to notifications, undertaking assessments and making decisions about a child – all workers must actively seek to acquire information from other agencies, and from their own case files, as a means of gaining a complete picture of a child's life. Incomplete information will often lead to poor decision-making and poor planning.
- Assessment of a parent's skills and capacity to parent their child or children, that is based on all available evidence including the social history of that parent. Multi-disciplinary assessment and specialist assessment must assist in decision making in complex cases.
- Comprehensive case management that is responsive to the complexity of the child's circumstances, is pro-active, and where necessary long-term, is needed to manage the increasingly complex needs of children and their families.
- Training for child protection workers must be such that it supports competent and confident practitioners. It must be child-centred, support the exchange of information, and teach the comprehensive assessment of risk and the importance of case management. It must teach practitioners about the legislative powers available to them under *the Act*, and it must be followed up within a learning and supervisory structure that supports the development of each practitioner's skills.

The submission further suggested that the Commission should consider:

- Whether it is in the best interests of children to separate investigative and intervention/therapeutic services.
- Changes to the internal death review process (the Adverse Events Committee) including a much clearer process for implementing and monitoring recommendations, a commitment to the review of the death of children who have been under the Guardianship of the Minister, regardless of the cause of death, access to a multi-disciplinary perspective, and the appointment of an independent Chair to that committee.

The Committee was directed by the Minister to conduct its own review into the death of Chloe Valentine and this review is currently being undertaken. Under legislation, this review could not commence until after the coronial inquest was completed. The Committee is also undertaking a review into the serious injury of a four year old child.

Both of these reviews raise the question of whether child protection, and also health and housing agencies, made the safety of each of these children the focus of their practice.

In May 2015, the Minister for Child Protection Reform introduced the *Children's Protection (Implementation of the Coroner's Recommendations) Amendment Bill 2015*. The Committee submitted its comments about this Bill to that Minister. In particular the Committee expressed concern about the proposed removal of the Principles of the *Children's Protection Act 1993* and queried whether the insertion of Part 5 Division 3 about persons *found guilty of a qualifying offence* would help to prevent children from suffering harm.

Future directions

It is the Committee's view that the child protection system must be clear about the scope of its role in relation to the protection of children. It must be child-focussed and it must ensure proactive engagement with children. Until these issues are addressed, the system will continue to miss opportunities to intervene, will fail to act or, when acting, will fail to effectively protect children from harm.

In 2015-16 the Committee will:

- Submit recommendations arising from its review about the circumstances of the death of Chloe Valentine and another seriously injured child that will address matters of policy and practice change.
- Conduct reviews and look for examples of effective practice and recognise and report on these improvements.
- Engage in ongoing dialogue with relevant senior officers, seeking confirmation of the ways in which its recommendations will be implemented and any impediments to those changes.

The Committee anticipates that the recommendations of the Royal Commission will also address the fundamental issues in case practice it has already identified.

1.7. The Health system's response to children

Many children have contact with health services in their lives. The Committee monitors the delivery of health services to infants, children and young people by reviewing the health services provided to children that have died or suffered serious injury. In the last

year, the Committee raised the issue of quality of service provision to children and their families experiencing disadvantage with SA Health in the following ways.

1.7.1. Discharge of vulnerable infants from hospital

Infants have been found to be at risk when they are discharged from a birth hospital into the care of a family with known child protection concerns or a high and complex level of need. In response to the 2012 review of 14 sudden and unexpected infant deaths, the Committee advocated for strengthening engagement with vulnerable families in the antenatal period, and the co-ordination of services after discharge.

The Committee considered the 'Collaborative Case Management of At Risk Infants in Birthing Hospitals' procedure implemented by SA Health and Families SA in March 2014. The policy and procedure provide an agreed process for birthing hospitals to coordinate with Families SA where an unborn infant has been identified as being 'at risk' and may be removed into care.

The Committee will monitor the use of the procedure and considers that there are opportunities to work positively on psycho-social issues with vulnerable women when they present for antenatal care to a hospital. The committee has seen no evidence that such antenatal, birth and newborn services to high risk families are being reliably, consistently and effectively provided in a cohesive manner. The Committee awaits the outcomes of the planned review by SA Health in 2016 into the implementation of the procedure.

An integrated, antenatal, birth and newborn service to high risk families, provided by Families SA and SA Health, is a critical element of early intervention and prevention.

1.7.2. Aboriginal Family Birthing Program

Aboriginal children are at least three times more likely to die than non-Aboriginal children. The Committee considers the high mortality rate of Aboriginal infants to be the beginning of poor outcomes for Aboriginal children.

The Aboriginal Family Birthing Program enables Aboriginal women to be cared for during pregnancy, labour and birth and in the postnatal period by Aboriginal Maternal and Infant Care workers in partnership with midwives, obstetricians and general practitioners.

The Committee has provided the Royal Commissioner into Child Protection Systems with the evaluation of the Aboriginal Family Birthing Program by the Murdoch Children's Research Institute, University of Adelaide and the Aboriginal Health Council of SA. This evaluation demonstrated an increased proportion of Aboriginal mothers receiving antenatal care, and the birth of fewer low-birth-weight infants.

The Committee remains concerned about the lack of security of funding to continue providing this service. The Committee has previously raised the need to expand this service state-wide to maximise its impact on the health and wellbeing of Aboriginal mothers and infants.

1.7.3. Mothers who did not consent to a Universal Contact Visit

Parents who refuse a Universal Contact Visit from a Child and Family Health nurse are sometimes from a high risk family and may warrant Families SA intervention.

An audit, conducted by the Women's and Children's Health Network, of postnatal services provided to women who did not consent to a Universal Contact Visit after birthing at the Women's and Children's Hospital, showed that the majority of women accessed other postnatal services. In 2014, the Women's and Children's Hospital adopted a joint planning process with the Department for Education and Child Development's Children's Centres as well as Child and Family Health Services, to better link community-based antenatal and postnatal services.

The Committee continues to be interested in the steps taken by these services to engage with women experiencing disadvantage.

1.7.4. Attendance at hospital appointments

The Committee's reviews have indicated that a proportion of families miss their child's hospital outpatient appointment for review or treatment of a medical condition. Attending regular outpatient appointments as advised by a doctor provides the best care. Missing or cancelling multiple medical appointments can be an indication of the family's lack of capacity to care for a child with a complex condition.

In June 2014, the Committee raised the need for the Women's and Children's Health Network (WCHN) to develop a procedure for contacting vulnerable families whose children miss medical appointments. The Women's and Children's Hospital has now updated its 'Failure to Attend' procedure.

The Committee notes the support of the WCHN Mortality Committee for annual organisation-wide audits of the efficacy of the 'Failure to Attend' procedure. The Committee will follow the implementation of processes such as annual audits of missed appointments, to ensure children from vulnerable families get the best possible care.

Families caring for children with complex medical conditions require good support from the health system.

1.7.5. SA Health practice changes

In 2014-15 the Committee sought responses from SA Health about the ways in which they had promoted clinical practice change for the following specific health conditions:

- ***Ventriculo-peritoneal shunts (VP shunts)*** Children with VP shunts are at risk of dying if a blocked shunt is not diagnosed.
    - WCHN developed a website which included information about the treatment of children with VP shunts.
    - SA Health advised parents to take their child to the nearest emergency department and inform medical staff they must contact the neurosurgical team at the WCHN when their child with a VP shunt is unwell. The Committee reminded SA Health that some parents may find its advice difficult to follow.
- ***Antibiotic provision to newborns*** The Committee supports South Australia's *Perinatal Practice Guidelines*[18] which advise that intrapartum antibiotics be provided to women in labour who have had a positive antenatal screening test for streptococcus. This practice provides the best chance of preventing the death of the infant infected with streptococcus soon after birth.
    - SA Health issued a safety notice designed to improve clinical handover in antenatal and neonatal settings and informed relevant clinical networks and services about the findings of a coronial inquest into an infant who died from streptococcus infection.

[18] *http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/perinatal+practice+guidelines/perinatal+practice+guidelines. Accessed October 2015.*

- ***Transfer of newborns with potential heart problems*** Infants born with undiagnosed cardiac problems can collapse and die quickly in the days following their birth.
    - SA Health has established a process to manage the transfer of newborns with a provisional diagnosis of major cardiac issues to the appropriate centre. The WCHN's Mortality Committee supported this practice change.

The Committee will continue to review the deaths of children from these specific health conditions and monitor the impact of the practice changes that have been made by SA Health.

1.7.6. Commenting on proposed health system changes

Children's needs should not be subsumed into the needs of families or service organisations in considering changes to the delivery of health services.

In 2014-15 the Committee provided feedback about proposed changes to both state and national health systems where they considered that these changes would impact on the delivery of services to children.

Changes to SA Health - *Transforming Health*[19]

SA Health is undergoing a process of change aimed at improving the quality, effectiveness and adaptability of the three South Australian metropolitan health networks. The Committee provided feedback to SA Health about the changes proposed in the *Transforming Health* process expressing its concerns about:

- Children living in rural and remote areas and the challenges of accessing metropolitan health services.
- Children who are experiencing high levels of disadvantage. They may be further disadvantaged by a system that creates even greater barriers to these families' access to healthcare.
- Children with disability and children of parents with a disability.
- Children with mental health issues, and children with parents who have mental health issues.

[19] http://transforminghealth.sa.gov.au/ *Accessed October 2015*

- Vulnerable young people who are 'transitioning' into adult-centred services.
- The provision of early opportunities for intervention in the antenatal period which encourages the best outcomes for mothers and infants, in particular, state-wide funding for the Aboriginal Family Birthing Program.

The Committee remains concerned about the visibility of children in the health system as a result of the *Transforming Health* changes.

Children must be visible to health services.

The *National Child and Youth Health Strategic Framework*[20]

The Committee provided feedback about the *National Child and Youth Health Strategic Framework* to the Australian Health Ministers' Advisory Council in October 2014, which included:

- The need to connect the measurement of health outcomes with actions that will improve the health and wellbeing of children and young people.
- The key factors associated with child death.
- The existence of child death review groups in each State.

The Committee will monitor the development and use of the *Framework*.

The measurement of health outcomes for Australian children provides a basis for policy development and service evaluation.

1.8. Building the future for children – a Children's Commissioner in South Australia

The South Australian government has deferred finalisation of legislation about a Children's Commissioner in South Australia until the Royal Commission into Child Protection Systems has made its recommendations.

The Committee supports the establishment of a Children's Commissioner and considers that:

[20] http://www.kidsfamilies.health.nsw.gov.au/current-work/programs/projects/national-child-and-youth-strategic-framework-for-health/ *Accessed October 2015*

- Children must be consulted about the proposed role and functions of the Commissioner. The Council for the Care of Children has reported on its consultations with children. The report about those consultations[21] should be taken into account when the proposed role and functions of the Commission are being considered.
- The Commissioner must advocate for children, and provide a focal point for drawing attention to their issues with the South Australian community.
- A Commissioner must have a broad mandate that gives a balance of investigative, advocacy, consultative, and enforcement powers.

[21] *Council for the Care of Children, Conversations Report 2015, http://www.childrensa.sa.gov.au/conversations-with-children-and-young-people-about-their-rights-and-a-commissioner.html*

Section Two

Child deaths South Australia 2005-14

S52T – Database

The Committee will maintain a database of child deaths and serious injury cases and their circumstances.

Children's Protection Act 1993

> *'the power of the child death review process for prevention lies in its ability to provide a systematic source of information on the underlying patterns of circumstances surrounding child deaths'.*

Covington T, Wirtz S. cited in Vincent S. Preventing Child Deaths. Learning from Review 2013 Dunedin Academic Press Ltd, Edinburgh.

2. Child deaths South Australia 2005-14

Opportunities for prevention and intervention to improve the safety and wellbeing of children can be identified through the systematic collection and analysis of information about death and serious injury.

2.1. Rates of child death 2005-14

The Committee's analysis is based on the deaths of children up to 18 years of age recorded by the Office of Births, Deaths and Marriages. Deaths after a spontaneous birth of an infant with a gestation of less than 20 weeks or a termination of pregnancy at any stage of gestation are not included in this analysis.

Table 1: Rates of child death, South Australia 2005-14

Year	All Children		Resident Children	
	Number	Rate[1] per 100 000	Number	Rate[1] per 100 000
2005	131	37.9	118	34.1
2006	118	34.1	109	31.5
2007	121	34.7	115	33.0
2008	112	32.0	103	29.4
2009	125	35.6	120	34.1
2010	115	32.6	113	32.0
2011	104	29.5	99	28.0
2012	98	27.6	93	26.2
2013	108	30.3	98	27.5
2014	95	26.5	89	24.8
2005-14	1127	32.0	1057	30.0

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16
Source: Child Death and Serious Injury Review Committee

The death rate for all children who died in South Australia in the ten years between 2005 and 2014 was 32.0 deaths per 100 000 children.

The death rate for children resident in South Australia was 30.0 deaths per 100 000 children.

2.2. Trends in child death rates 2005-14

Trends over time and mapping of child death rates provide useful information when services for children are being planned.

Table 2: Trends in child death rates[1], South Australia 2005-14

Year	All[2]	ATSI[3]	FSA[4]	IMR[5]	SUDI[6]	I&D[7]	Ext[8]	Trans[9]
2005-2014	**32.0**	**105.5**	**8.2**	**3.3**	**0.8**	**21.3**	**7.9**	**3.2**
2005	37.9	139.2	8.7	4.4	1.1	24.3	11.0	4.3
2006	34.1	90.1	8.9	3.3	1.1	19.4	11.8	3.2
2007	34.7	106.5	8.3	3.9	1.0	22.4	9.2	4.6
2008	32.0	90.1	7.4	3.2	0.7	22.0	7.7	3.1
2009	35.6	87.6	9.1	3.4	0.8	23.9	8.3	3.4
2010	32.6	63.7	8.8	3.5	1.0	21.5	7.1	3.7
2011	29.5	103.6	9.9	2.8	0.7	21.0	5.7	1.7
2012	27.6	103.6	7.6	2.8	0.3	19.7	5.9	2.5
2013	30.3	151.4	7.3	3.1	0.6	20.7	6.7	2.0
2014	26.5	119.5	6.4	2.6	0.5	17.8	6.1	3.1
p value	0.005	0.5	0.8	0.02	0.009	0.2	0.001	0.06

1 Rates have been calculated per 100 000 children using ABS population estimates for children between 0-17 years with the exception of the Infant Mortality Rate which is calculated per 1000 live births. See Section 4.16
2 All children who died in South Australia
3 Aboriginal children
4 Children or their families who had contact with Families SA in the three years prior to their death
5 Infant mortality rate – rate per 1000 live births
6 Sudden and unexpected death of an infant - rate per 1000 live births
7 Death attributed to illness or disease
8 Death attributed to external causes including deliberate acts, neglect, suicide, transport incidents, drowning and various kinds of accidents such as falls, poisoning and suffocation
9 Deaths attributed to transport incidents
Source: Child Death and Serious Injury Review Committee database

For the period between 2005 and 2014:

- ***The death rate for all children who died in South Australia showed a 2% decrease on average per year (p=0.005)***
- ***Although the death rate for Aboriginal children has fluctuated over individual years, no trend was found (p=0.5)***
- ***The rate of death due to SUDI declined by 7% on average per year (p=0.009)***
- ***Deaths attributed to transport incidents (40% of the deaths due to external causes) declined by 6% on average per year (p=0.06).***

Figure 1: Trends in Aboriginal and all child death rates from 2005-14, South Australia

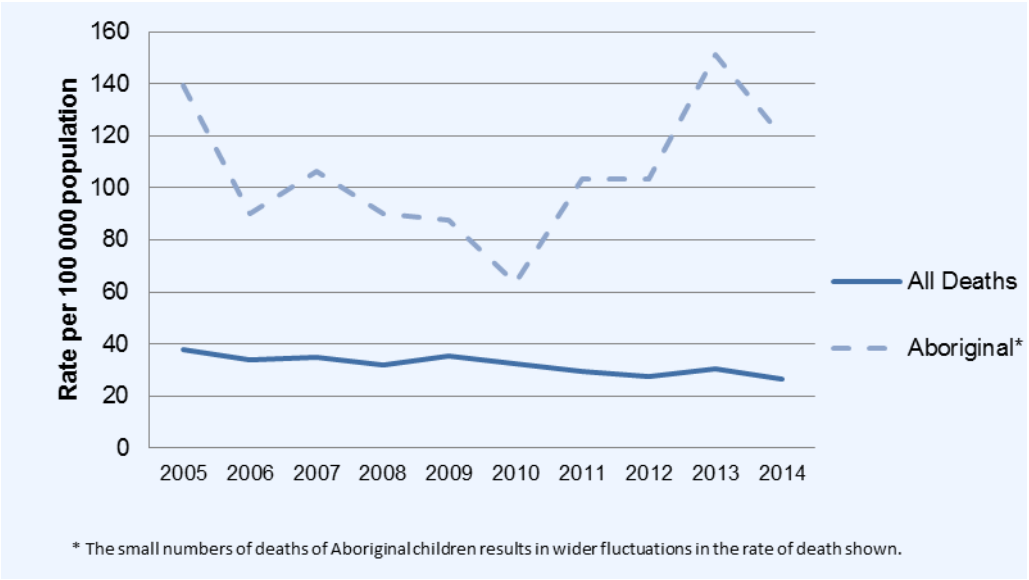


Figure 2: Trends in deaths from transport incidents, external and all causes from 2005-14, South Australia

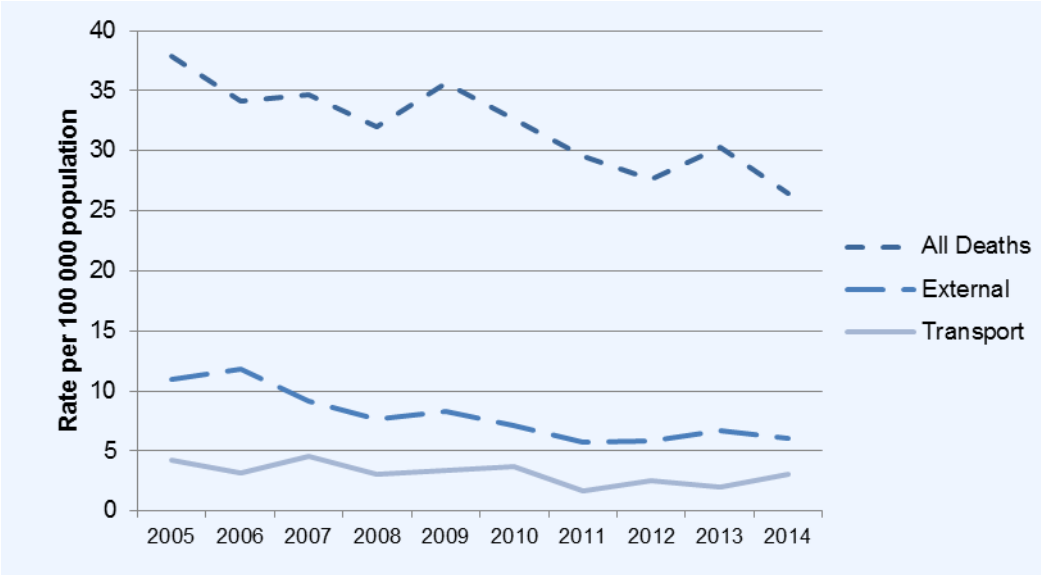
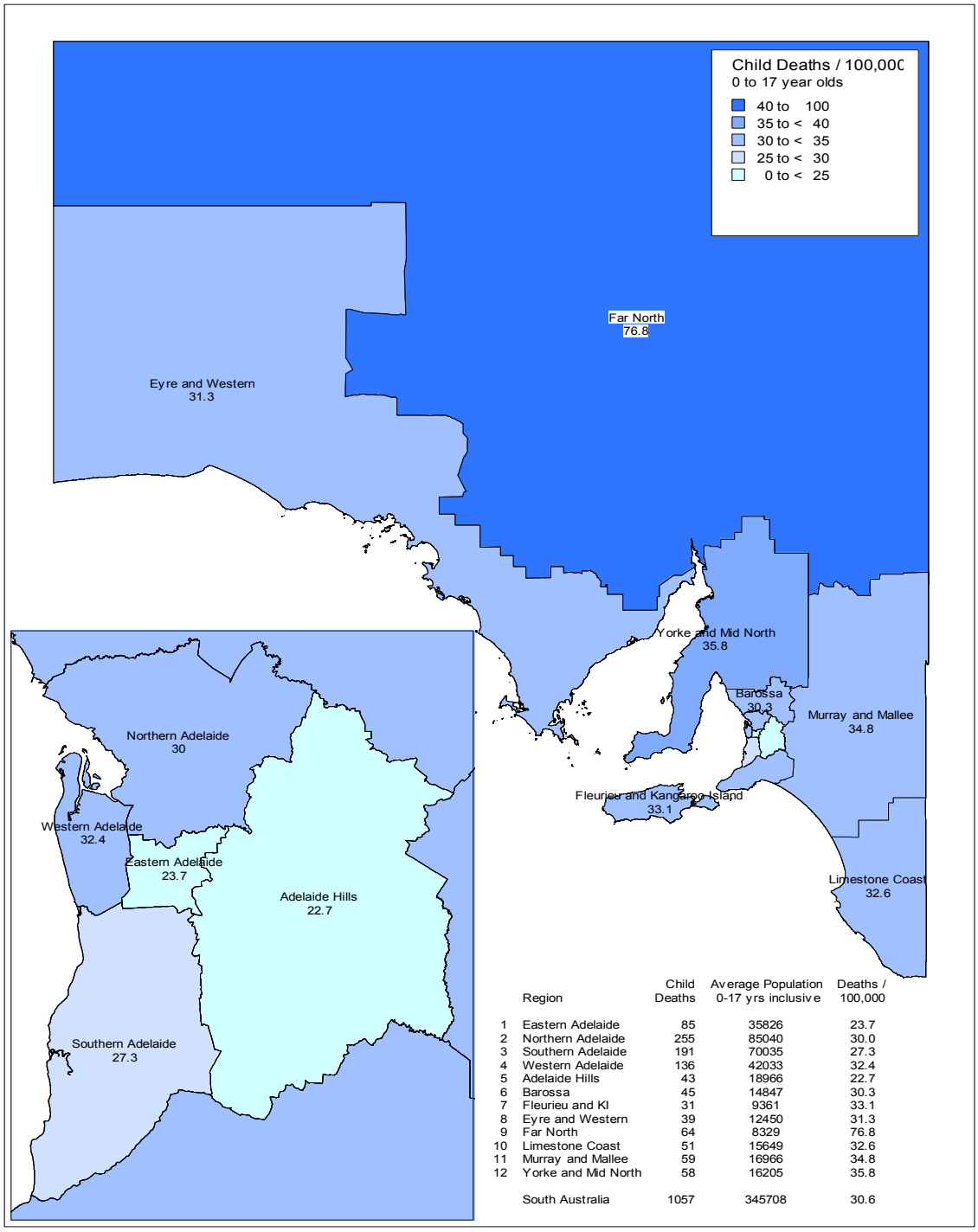


Figure 3: Child death rates by region, South Australia 2005-14



	Region	Child Deaths	Average Population 0-17 yrs inclusive	Deaths / 100,000
1	Eastern Adelaide	85	35826	23.7
2	Northern Adelaide	255	85040	30.0
3	Southern Adelaide	191	70035	27.3
4	Western Adelaide	136	42033	32.4
5	Adelaide Hills	43	18966	22.7
6	Barossa	45	14847	30.3
7	Fleurieu and KI	31	9361	33.1
8	Eyre and Western	39	12450	31.3
9	Far North	64	8329	76.8
10	Limestone Coast	51	15649	32.6
11	Murray and Mallee	59	16966	34.8
12	Yorke and Mid North	58	16205	35.8
	South Australia	1057	345708	30.6

Aboriginal children comprised almost 50% of the children resident in the far north region.

2.3. Demographics of child death 2005-14

Table 3: Demographics of child death, South Australia 2005-14

	2005–06	2007–08	2009–10	2011–12	2013–14	2005–14	Rate[1] per 100 000 2005–2014
Total	**249**	**233**	**240**	**202**	**203**	**1127**	**32.0**
Sex							
Female	125	83	96	94	84	482	28.1
Male	124	150	144	108	119	645	35.8
Age Group							
Infants (<1 year)[2]	142	140	136	111	117	646	327.7
1-4 years	36	27	31	29	31	154	20.3
5-9 years	18	16	11	21	15	81	8.5
10-14 years	18	13	21	14	20	86	8.7
15-17 years	35	37	41	27	20	160	25.8
Cultural Background							
Aboriginal	28	24	19	26	34	131	105.5
Contact with Families SA[3]							
Families SA	61	55	63	62	49	290	
Usual Residence							
Outside SA	22	15	7	10	16	70	
Socioeconomic Background (SEIFA IRSD)[4]							
Most disadvantaged SEIFA 5	65	75	82	65	63	350	39.5
SEIFA 4	58	46	52	39	36	231	29.8
SEIFA 3	45	44	49	40	35	213	35.0
SEIFA 2	33	26	28	30	28	145	22.6
Least disadvantaged SEIFA 1	26	27	22	18	25	118	19.6
Remoteness (ARIA)[4]							
Major City	144	152	151	121	129	697	27.7
Inner Regional	27	24	34	21	22	128	30.6
Outer Regional	35	26	41	43	29	174	38.8
Remote and Very Remote	21	16	7	7	7	58	44.8

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 Death rates for Families SA are not included. See Section 4.16.
4 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

In the period between 2005 and 2014:

- ***Children younger than one year and young people 15-17 years had a higher rate of death than those children aged between 1-14 years***
- ***Male children had a higher death rate than female children***
- ***Two hundred and ninety children who died (26%), or their families, had contact with Families SA in the three years before death***
- ***Children who lived in areas of greatest disadvantage had a higher rate of death than those who lived in areas of least disadvantage***
- ***Living in a remote area was associated with a higher child death rate in comparison to living in a major city area.***

2.4. Groups of children

Children living with disability, poverty, Aboriginal children or those who have contact with the child protection system are more likely to be at risk of poorer health. The deaths of these children are considered in more detail in the following sections of the report.

2.4.1. Deaths of Aboriginal children

The death rate for Aboriginal children continues to be much higher than the death rate for non-Aboriginal children.

In the ten year period between 2005 and 2014, 25 Aboriginal children died who were not normally resident in South Australia at the time of their death. Nineteen of these children were resident in the Northern Territory. The majority of these children died in South Australian hospitals from causes attributed to illness or disease. These deaths reflect cross-border arrangements whereby seriously ill children are brought to South Australia for high level medical care.

Table 4: Demographics of Aboriginal child death, South Australia 2005-14

	2005–06	2007–08	2009–10	2011–12	2013–14	2005–14	Rate[1] per 100 000 2005–14
Total	**28**	**24**	**19**	**26**	**34**	**131**	**105.5**
Sex							
Female	10	12	8	11	15	56	91.4
Male	18	12	11	15	19	75	116.8
Age Group							
Infants (<1 year)	15	15	9	17	18	74	10.8[2]
1-4 years	2	3	1	1	7	14	48.1
5-9 years	2	1	0	3	1	7	20.4
10-14 years	3	1	3	1	6	14	40.5
15-17 years	6	4	6	4	2	22	110.3
Contact with Families SA[3]							
Families SA	13	14	13	21	19	80	
Usual Residence							
Outside SA	8	5	4	1	7	25	
Socioeconomic Background (SEIFA IRSD)[4]							
Most disadvantaged SEIFA 5	16	13	9	17	20	75	NA[5]
SEIFA 4	2	1	3	4	5	15	NA
SEIFA 3	2	2	3	1	2	10	NA
SEIFA 2	0	3	0	2	0	5	NA
Least disadvantaged SEIFA 1	0	0	0	1	0	1	NA
Remoteness (ARIA)[4]							
Major City	7	6	9	10	7	39	NA
Inner Regional	0	0	0	0	3	3	NA
Outer Regional	7	3	5	11	14	40	NA
Remote and Very Remote	6	10	1	4	3	24	NA

1 Rates for Aboriginal children have been calculated using the Estimated Resident population of Aboriginal children aged younger than 18 years. See Section 4.16.
2 The infant mortality rate is calculated per 1000 live births. See Section 4.16.
3 Death rates for Families SA are not included. See Section 4.16.
4 South Australian residents only included.
5 Not Available
Source: Child Death and Serious Injury Review Committee database

In relation to the deaths of Aboriginal children between 2005 and 2014:

- ***Aboriginal children were 3.6 times more likely to die than non-Aboriginal children***
- ***Although the death rate has fluctuated over individual years, no trend was found (p=0.5)***

Table 5: Aboriginal child death by age and cause of death, South Australia 2005-14

Causes of Death	Infants < 1 year	1-9 years	10–17 years	Total	Rate[1] per 100 000 2005-14
2014					
Illness or Disease	6	0	2	8	63.7
Undetermined Causes	0	0	0	0	
SIDS[3]	0	0	0	0	
External Causes	0	4	2	6	47.8
Total	**7[2]**	**4**	**4**	**15**	**119.5**
2005-14					
Illness or Disease	53	10	11	74	59.6
Undetermined Causes	13	1	0	14	11.3
SIDS[3]	3	0	0	3	43.8[3]
External Causes	4	10	25	39	31.4
Total	**74[2]**	**21**	**36**	**131**	**105.5**

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 There was one infant death where the cause of death had not yet been determined.
3 Death rates for SIDS are calculated per 100 000 Aboriginal live births. See Section 4.16.
Source: Child Death and Serious Injury Review Committee database

In the period 2005 to 2015 the majority of deaths were infants younger than one year. Thirty-seven infants (50%) died from conditions associated with their premature birth

The second highest death rate was in the 15-17 year old age group and these young people were more likely to die from external causes, including eight young people who died in transport crashes and seven who suicided.

2.4.2. Deaths of children with disability

Families caring for children with a disability face significant challenges in accessing services and support for their children. Information on all deaths of South Australian children is reviewed each year by the Committee to determine whether a child's daily activities had been significantly limited because of a disability. Section 4.9 provides further information about the classification of disability and its subtypes.

In the ten year period between 2005 and 2014:

- ***Two hundred and forty-nine of the 1127 children who died aged 0-17 years (22%) had a disability that impacted on their daily living***
- ***Although the death rate for all children with disability has fluctuated, no significant trend was found (p=0.8).***
- ***The death rate for children with a disability aged 1 to 4 years has decreased by 10% on average per year (p= 0.06) and increased by 9% on average in children aged 5 to 14 years (p=0.05)***
- ***Aboriginal children with a disability were 2.5 times as likely to die than non-Aboriginal children with a disability***
- ***Male children with a disability had a higher rate of death than female children with disability***
- ***The death rate for children with disability was higher in areas of socioeconomic disadvantage than in less disadvantaged areas***
- ***Extremely small numbers of children with disability died in remote and very remote areas of the State***

Table 6: Demographics of deaths of children with disability, South Australia 2005-14

	2005–06	2007–08	2009–10	2011–12	2013–14	2005–14	Rate[1] per 100 000 2005–14
Total	**43**	**46**	**65**	**46**	**49**	**249**	**7.1**
Sex							
Female	25	18	24	22	23	112	6.5
Male	18	28	41	24	26	137	7.6
Age Group							
Infants (<1 year)	21	29	29	22	24	125	63.4[2]
1-4 years	12	8	8	6	6	40	5.3
5-9 years	7	3	7	6	6	29	3.0
10-14 years	1	2	13	8	9	33	3.3
15-17 years	2	4	8	4	4	22	3.5
Cultural Background							
Aboriginal	4	3	3	4	7	21	16.9
Contact with Families SA[3]							
Families SA	9	11	17	10	15	62	
Usual Residence							
Outside SA	3	4	2	1	2	12	
Socioeconomic Background (SEIFA IRSD)[4]							
Most disadvantaged SEIFA 5	15	12	20	16	17	80	9.0
SEIFA 4	6	12	17	6	5	46	5.9
SEIFA 3	6	9	14	12	11	52	8.5
SEIFA 2	7	6	6	7	7	33	5.1
Least disadvantaged SEIFA 1	6	3	6	4	7	26	4.3
Remoteness (ARIA)[4]							
Major City	25	27	47	31	37	167	6.6
Inner Regional	3	6	7	4	5	25	6.0
Outer Regional	10	7	8	8	5	38	8.5
Remote and Very Remote	2	2	1	2	0	7	5.4

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 Death rates for Families SA are not included. See Section 4.16.
4 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

Deaths of children with disability aged 1-17 years old

The Committee has determined the disability types associated with child deaths and disability for children aged 1-17 years.

Table 7: Deaths of children with disability 1-17 years old, disability type and age, South Australia 2005-14

Disability type[1]	1-9 years	10–17 years	Total n=124	Rate[2] per 100 000 2005-14
Neurodegenerative disease, genetic disorder and birth defects	43	21	64	1.8
Cerebral palsy	13	20	33	1.0
Epilepsy	13	19	32	1.0
Heart and circulatory problems	11	2	13	0.4
Intellectual disability	2	6	8	0.2
Autism	1	3	4	0.1
Other disability types	6	4	10	0.3

1 Children with multiple disabilities have been included in all relevant disability subtypes
2 Rates have been calculated using ABS population estimates for children between 1-17 years. See Section 4.16.
Source: Child Death and Serious Injury Review Committee database

Figure 4: Deaths of children with disability 1-17 years old by disability type and age, South Australia 2005-14

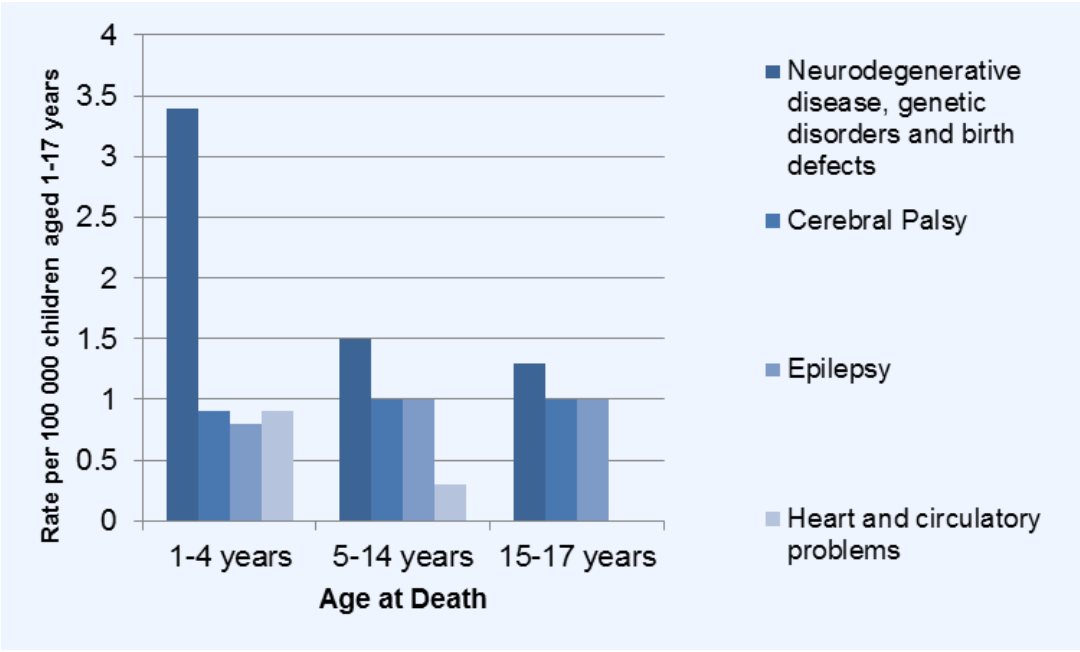


Table 8: Deaths of children with disability 1-17 years old and cause of death, South Australia 2005-14

Disability type[1]	I&D[2]	Tr[3]	Delib[4]	Dro[5]	Sui[6]	Undet[7]	Acc[8]	Total n=124
Neurodegenerative disease, genetic disorder and birth defects	57	0	0	2	2	1	0	64[9]
Cerebral palsy	30	0	0	1	0	0	0	33[9]
Epilepsy	28	0	0	2	0	0	0	32[9]
Heart and circulatory problems	13	0	0	0	0	0	0	13
Intellectual disability	3	1	1	0	0	1	2	8
Autism	0	0	0	1	1	1	1	4
Other disability types	7	0	0	1	0	0	0	10[9]

1 Children with multiple disabilities have been included in all relevant disability types
2 Deaths of children aged 1-17 with a disability attributed to illness and disease
3 Deaths of children aged 1-17 with a disability attributed to transport incidents
4 Deaths of children aged 1-17 with a disability attributed to deliberate acts
5 Deaths of children aged 1-17 with a disability attributed to drowning
6 Deaths of children aged 1-17 with a disability attributed to suicide
7 Deaths of children aged 1-17 with a disability attributed to undetermined causes
8 Deaths of children aged 1-17 with a disability attributed to accidents
9 There were two deaths attributed to other causes in each of these totals.
Source: Child Death and Serious Injury Review Committee database

In the ten year period between 2005 and 2014:

- ***Trends in death rates for types of disability varied and no trend reached statistical significance:***
  - ***cerebral palsy – a 10% increase on average per year (p=0.1),***
  - ***epilepsy – a 4% increase (p=0.5),***
  - ***neurodegenerative disease, genetic disorders and birth defects – a 2% increase (p=0.6)***
- ***Most deaths of children with a disability were attributed to illness and disease***
- ***Children with intellectual disability or autism died from various causes including drowning and suicide.***

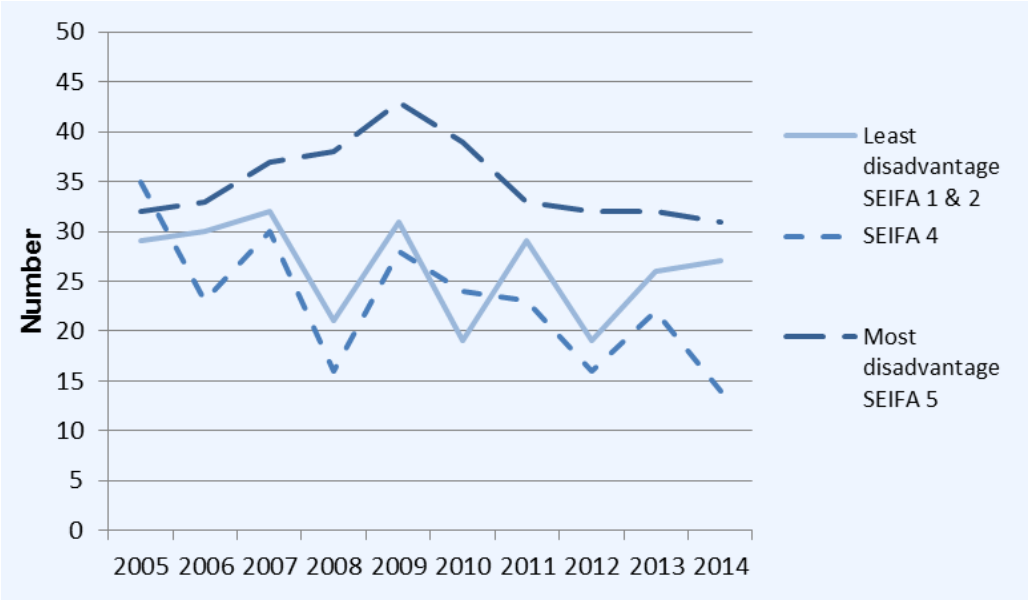
2.4.3. Deaths of children from disadvantaged areas

The connection between child death and disadvantage is very strong. In a recent series of articles about child death review it was noted that:

> ***'Relative poverty is highlighted as the most important social determinant for child deaths in high-income countries. The authors identify a persistent – across all causes and in time – inverse association between socioeconomic status and child mortality in high-income countries.***[22]

Socio-Economic Indices for Areas (SEIFA) are a measurement that rank areas in Australia according to relative socio-economic advantage and disadvantage. The indexes are based on information from the five-yearly Census.

Figure 5: Child deaths by SEIFA and year of death, South Australia, 2005-14



Children who lived in areas of greatest disadvantage had a higher rate of death than those who lived in areas of least disadvantage.

The death rate for children who lived in areas classified as SEIFA 4 and died in South Australia showed a 6% decrease on average per year (p=0.004). Although the death rate for children in the most disadvantaged area (SEIFA 5) fluctuated, there was no trend (p=0.6).

[22] *The Lancet V 384 p830 Child deaths: inequity and inequality in high-income countries.*

2.4.4. Deaths of children in contact with the child protection system[23]

Table 9: Demographics of child death and contact with Families SA, South Australia 2005-14

	Number of deaths per year					Total	Rate[1] per 100 000 2005–14
	2005–06	2007–08	2009–10	2011–12	2013–14		
Total	**61**	**55**	**63**	**62**	**49**	**290**	**8.2**
Sex							
Female	28	17	24	26	19	114	6.6
Male	33	38	39	36	30	176	9.8
Age Group							
Infants (<1 year)	25	30	29	33	16	133	67.5[2]
1-4 years	11	10	10	9	13	53	7.0
5-9 years	4	3	5	6	5	23	2.4
10-14 years	9	5	7	3	7	31	3.1
15-17 years	12	7	12	11	8	50	8.1
Cultural Background							
Aboriginal	13	14	13	21	19	80	64.4
Usual Residence							
Outside SA	2	2	0	1	1	6	
Socioeconomic Background (SEIFA IRSD)[3]							
Most disadvantaged SEIFA 5	28	22	35	30	27	142	16.0
SEIFA 4	16	13	12	13	10	64	8.3
SEIFA 3	9	9	11	7	6	42	6.9
SEIFA 2	4	4	3	6	3	20	3.1
Least disadvantaged SEIFA 1	2	5	2	5	2	16	2.7
Remoteness (ARIA)[3]							
Major City	32	31	38	35	27	163	6.5
Inner Regional	6	6	4	4	7	27	6.4
Outer Regional	14	8	20	19	11	72	16.1
Remote and Very Remote	7	8	1	3	3	22	17.0

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

[23] *To be included in this section of the report, the child or a member of their family must have had some form of contact with Families SA within three years of the incident resulting in their death.*

Table 10: Child death and contact with Families SA by age and cause of death, South Australia 2005-14

Causes of Death	Infants < 1 year	1-9 years	10–17 years	Total	Rate[1] per 100 000 2005-14
2014					
Illness or Disease	2	5	1	8	2.2
Undetermined Causes	2	1	0	3	0.8
SIDS[2]	0	0	0	0	
External Causes	0	5	6	11	3.1
Total	**5**	**11**	**7**	**23**	**6.4**
2005-2014					
Conditions in the perinatal period	45	2	0	47	1.3
Congenital and chromosomal abnormalities	23	6	2	31	0.9
Cancers	0	11	5	16	0.5
All other illness or disease	12	15	17	44	1.3
Illness or Disease	**80**	**34**	**24**	**138**	**3.9**
Undetermined Causes	**37**	**7**	**1**	**45**	**1.3**
SIDS[2]	**4**	**0**	**0**	**4**	**2.0[2]**
Transport	1	8	23	32	0.9
Suicide	0	0	18	18	0.5
Accidents	7	6	9	22	0.6
Deliberate acts	2	7	2	11	0.3
Neglect	1	2	2	5	0.1
All other external causes	0	12	2	14	0.4
External Causes	**11**	**35**	**56**	**102**	**2.9**
Total	**133**	**76**	**81**	**290**	**8.2**
Disability[3]	**20**	**24**	**18**	**62**	**1.8**

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 Death rates for SIDS are calculated per 100 000 live births. See Section 4.16.
3 Children who have been determined to have a disability.
Source: Child Death and Serious Injury Review Committee database

Death rates are calculated using the number of children in South Australia, rather than the number of children in contact with Families SA, which is not readily available. This rate only allows for comparison across years (see Section 4.16).

For children or their families who had had contact with Families SA between 2005 and 2014:

- ***Illness or disease accounted for the greatest number of deaths. Over half of these deaths were of infants younger than one year***
- ***Aboriginal children had a higher rate of death than non-Aboriginal children***
- ***The majority of children and their families lived in the State's most disadvantaged areas.***
- ***Although the death rate has fluctuated over individual years, no trend was found (p= 0.4).***
- ***Twenty-one percent of children (62 children) were determined to have a disability.***

Table 11: Deaths of children under guardianship, South Australia 2005-14

	2005-14	Rate[1] per 100 000 2005–14
Total	**20**	**0.6**
Sex		
Female	8	0.5
Male	12	0.7
Age Group		
0-4 years	5	0.5
5-14 years	6	0.3
15-17 years	9	1.5
Cultural Background		
Aboriginal	12	9.7
Usual Residence		
Outside SA	2	
Socioeconomic Background (SEIFA IRSD)[2]		
Most disadvantaged SEIFA 4 and 5	11	0.7
Least disadvantaged SEIFA 1, 2 and 3	7	0.4
Remoteness (ARIA)[2]		
Major City	9	0.4
Regional and Remote	9	0.9
Cause of Death		
Disability	12	0.3
Transport	5	0.1
Other	3	0.1

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

In the period between 2005 and 2014:

- ***Most deaths of children under guardianship were of children with a disability.***
- ***Sixty percent of deaths of children under guardianship, were of Aboriginal children.***

Table 12: Deaths of children with a parent who has a history of guardianship, South Australia 2005-14

	2005-14	Rate[1] per 100 000 2005–14
Total	**14**	**0.4**
Sex		
Female	9	0.5
Male	5	0.5
Age Group		
Infants (<1 year)[2]	12	6.1
1-17 years	2	0.1
Cultural Background		
Aboriginal	6	4.8
Usual Residence		
Outside SA	2	
Socioeconomic Background (SEIFA IRSD)[3]		
Most disadvantaged SEIFA 4 and 5	8	0.5
Least disadvantaged SEIFA 1, 2 and 3	4	0.2
Remoteness (ARIA)[3]		
Major City	6	0.2
Regional and Remote	6	0.6
Cause of Death		
Complications of Prematurity	8	0.2
Other	6	0.2

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

In the period between 2005 and 2014, over half the deaths of children whose parent had a history of guardianship, were due to complications of prematurity.

2.5. Causes of child death and age at death

Table 13: Causes of child death by age group, South Australia 2005-14

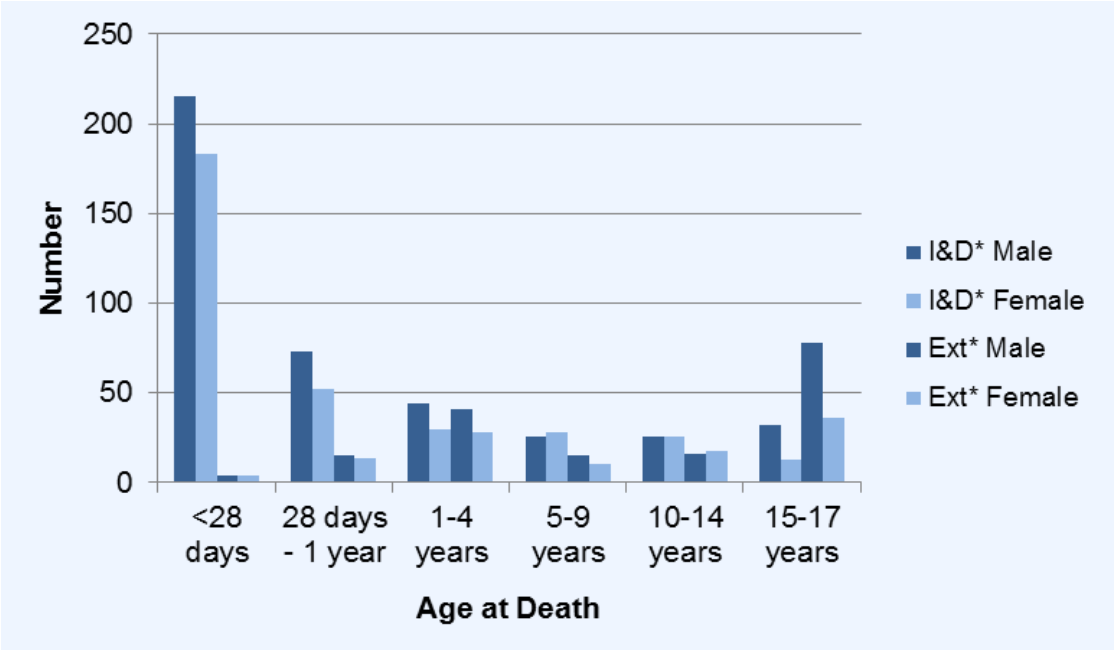
Causes of Death	Age at death							Rate[1] per 100 000 2005-14
	< 28 days	28 days – 1 year	1-4 years	5-9 years	10-14 years	15–17 years	Total	
Certain infectious and parasitic diseases	2	12	3	0	1	1	19	0.5
Cancer	2	2	22	23	15	14	78	2.2
Endocrine, nutritional and metabolic diseases	4	4	6	3	3	6	26	0.7
Diseases of the nervous system	8	17	15	10	15	8	73	2.1
Diseases of the circulatory system	1	9	5	4	2	3	24	0.7
Diseases of the respiratory system	0	6	4	4	5	4	23	0.7
Certain conditions originating in the perinatal period	283	33	3	1	1	2	323	9.2
Congenital malformations, deformations and chromosomal abnormalities	98	39	14	9	7	5	172	4.9
Illness or Disease[2]	**398**	**125**	**74**	**54**	**52**	**45**	**748**	**21.3**
Undetermined Causes	**12**	**56**	**11**	**2**	**0**	**1**	**82**	**2.3**
SIDS[3]	**0**	**14**	**0**	**0**	**0**	**0**	**14**	**7.1[3]**
Transport	2	3	20	11	16	59	111	3.2
Drowning	0	3	15	4	2	2	26	0.7
Accidents	2	13	9	6	6	10	46	1.3
Deliberate acts	1	6	13	1	2	6	29	0.8
Suicide	0	0	0	0	2	36	38	1.1
External Causes[4]	**8**	**29**	**69**	**25**	**34**	**114**	**279**	**7.9**
Cause not yet known	0	4	0	0	0	0	4	
Total	**418**	**228**	**154**	**81**	**86**	**160**	**1127**	**32.0**

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 Ten deaths were due to other causes of illness and disease
3 Death rates for SIDS are calculated per 100 000 live births. See Section 4.16.
4 Twenty-nine deaths were due to other external causes
Source: Child Death and Serious Injury Review Committee database

In the ten year period between 2005 and 2014:

- *The majority of deaths were attributed to illness or disease (66%). Of these, most deaths were due to conditions originating in the perinatal period and deaths due to congenital malformation, deformations and chromosomal abnormalities*
- *There were 418 deaths in the neonatal period (less than 28 days of life) and 228 deaths in the post-neonatal period (28 days to 1 year of life)*
- *Between 1-17 years, approximately equal numbers of children died from illness or disease as from external causes*
- *Seventy-eight deaths were attributed to cancer.*[24]

Figure 6: Death from illness and disease and external causes by age and sex, South Australia 2005-14



[24] *Cancer in South Australia 2009 http://www.sahealth.sa.gov.au/wps/wcm/connect/48188b804fc4c928a01cba5cbc1ea1e9/CancerInSA2009-Epidemiology-20130601.pdf?MOD=AJPERES&CACHEID=48188b804fc4c928a01cba5cbc1ea1e9 Accessed September 2014.*

2.5.1. Infant mortality

Table 14: Demographics and cause of infant deaths, South Australia 2005-14

	Age at Death				Total infants	Rate[1] per 1000 2005-14
	< 1 day	1 -6 days	7-27 days	28 days – 1 year		
Sex						
Female	105	44	44	92	285	3.0
Male	130	48	47	136	361	3.6
Cultural Background						
Aboriginal	24	6	6	38	74	10.8
Causes of Death						
Certain conditions originating in the perinatal period	188	55	40	33	316	1.6
Congenital malformations, deformations and chromosomal abnormalities	40	31	27	39	137	0.7
All other causes of death	3	3	11	53	70	0.4
Illness or Disease	**231**	**89**	**78**	**125**	**523**	**2.7**
Undetermined Causes	**0**	**2**	**10**	**56**	**68**	**0.3**
SIDS	**0**	**0**	**0**	**14**	**14**	**0.07**
Accidents	0	0	2	13	15	0.08
Deliberate acts	1	0	0	6	7	0.04
Transport	1	1	0	3	5	0.03
Drowning	0	0	0	3	3	0.02
External Causes[2]	**4**	**1**	**3**	**29**	**37**	**0.2**
Cause not yet known	**0**	**0**	**0**	**4**	**4**	
Total	**235**	**92**	**91**	**228**	**646**	**3.3**

1 Rate per 100 000 live births
2 Seven deaths were due to other external causes
Source: Child Death and Serious Injury Review Committee database

Details were obtained from Perinatal Death Certificates for all infants who died before 28 days of age. Further information about causes of death before 28 days of life is available in the infant mortality publications produced by the Pregnancy Outcome Unit of SA Health.[25]

[25] *Maternal, perinatal and infant mortality in South Australia 2011 http://www.sahealth.sa.gov.au/wps/wcm/connect/6833fa0041ffdd8495b6bdf8b1e08c6d/13103.2+Mortality+Report+A5-ONLINE.pdf?MOD=AJPERES&CACHEID=6833fa0041ffdd8495b6bdf8b1e08c6d Accessed September 2014.*

Information about infant mortality in South Australia is recorded in a number of different statistical collections including this Committee, the Australian Bureau of Statistics, and the South Australian Maternal and Perinatal Mortality Committee. Each collection has different ways of registering and recording the deaths of infants, resulting in slight differences in infant mortality rates.

In the ten year period between 2005 and 2014:

- ***The infant mortality rate declined by 3% on average per year (p=0.01)***
- ***Of the deaths of infants from illness or disease, 44% were younger than twenty-four hours***
- ***The most frequent causes of infant death from illness and disease were attributed to conditions originating in the perinatal period and deaths due to congenital malformation, deformations and chromosomal abnormalities***[26]
- ***Prematurity and its complications were often involved in the deaths of children with conditions originating in the perinatal period and congenital malformations.***

[26] *The South Australian Birth Defects Register publishes a comprehensive annual report of the epidemiology of birth defects in South Australia.*

Sudden unexpected deaths of infants

Sudden unexpected death in infancy (SUDI) has been described as an 'umbrella' term that is used for all sudden unexpected deaths of infants younger than one year of age.

Sudden infant death syndrome (SIDS) occurs when infants died during sleep, but no anatomical, biochemical, microbiological, neuropathological or other indicator of the cause of death could be found at post mortem. (See Section 4.8.7)

Table 15: Demographics and cause of SUDI deaths, South Australia 2005-14

	Total	Rate[1] per 1000 2005-14
Sex		
Female	61	0.6
Male	91	0.9
Cultural Background		
Aboriginal	27	3.9
Contact with Families SA[2]		
Families SA	66	
Socioeconomic Background (SEIFA IRSD)[3]		
Most disadvantaged SEIFA 4 and 5	101	NA
Least disadvantaged SEIFA 1, 2 and 3	50	NA
Remoteness (ARIA)[3]		
Major City	96	NA
Regional and Remote	55	NA
Causes of Death		
Illness and Disease	37	0.2
Other	30	0.2
Undetermined	68	0.3
SIDS	14	0.07
Cause of death not yet known	3	
Total	**152**	**0.8**

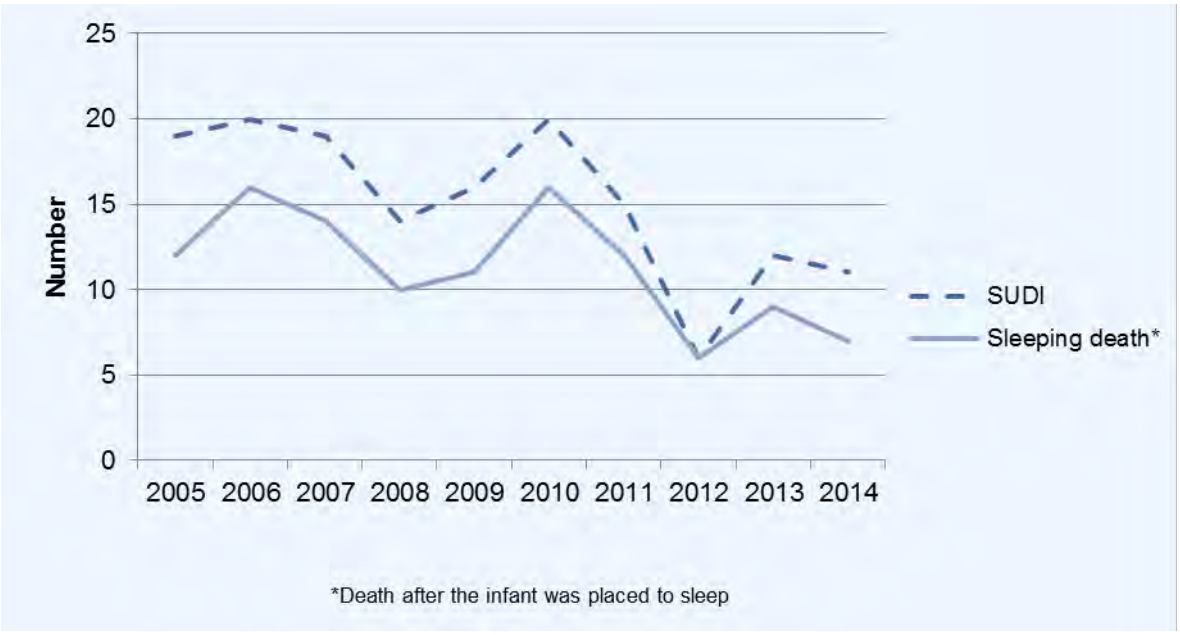
1 Rate per 1000 live births
2 Death rates for Families SA are not included. See Section 4.16.
3 South Australian residents only. Death rates are not available.
Source: Child Death and Serious Injury Review Committee database

In the ten year period between 2005 and 2014:

- ***The rate of death due to SUDI declined by 7% on average per year (p=0.009)***
- ***Twenty-six deaths were of neonates (less than 28 days) and 126 were post-neonatal deaths***
- ***Two thirds of these infants lived in the State's most disadvantaged areas (SEIFA 4 and 5)***
- ***Thirty-six percent of these infants lived in regional and remote locations***
- ***Almost half (43%) of these infants or their families, had contact with Families SA in the three years before their death.***

Sudden unexpected infant death often occurs when the infant is placed to sleep. At autopsy, the death may be attributed to causes such as illness, disease or suffocation. The majority of these 'sleeping deaths' remain unexplained and will be attributed to an undetermined cause (where no one manner of death is more compelling than other possible causes) or to SIDS (where no explanation for the infant's death can be found).

Figure 7: Death from SUDI by year, South Australia 2005-14



The rate of death of infants who died after they were placed to sleep declined over the period 2005-14 by 6% on average per year (p=0.04).

2.6. Child death attributed to undetermined causes, 1-17 year olds

A child's death is attributed to an undetermined cause when, after consideration of all information, no one manner of death is more compelling than other possible causes. For information about the deaths of infants attributed to undetermined causes, see section 2.5.1.

In the period between 2005 and 2014:

- ***There were 14 deaths of children aged 1-17 years attributed to undetermined causes***
- ***Undetermined causes were attributed more often to deaths of 1-4 year olds (11 deaths) than 5-17 year olds (3 deaths)***
- ***All deaths of 1-4 year olds attributed to undetermined causes occurred after they were placed to sleep.***

2.7. Child death attributed to external causes

This section describes deaths from deliberate acts, neglect, suicide, transport incidents, drowning and various kinds of accidents including falls, poisoning and suffocation. Deaths attributed to health system-related adverse events are also included. The criteria used to classify deaths into each of these categories are detailed in Section 4.8.

Table 16: External causes of child death by year and cause of death, South Australia 2005-14

Causes of Death	2005-06	2007-08	2009-10	2011-12	2013-14	Total	Rate[1] per 100 000 2005-14
Transport	26	27	25	15	18	111	3.2
Accidents	13	13	5	5	10	46	1.3
Suicide	8	3	8	8	11	38	1.1
Deliberate acts	7	7	8	5	2	29	0.8
Drowning	7	6	5	5	3	26	0.7
Health system-related adverse events	9	3	1	1	0	14	0.4
Fire-related	5	0	1	1	2	9	0.3
Neglect	4	0	1	1	0	6	0.2
Total	79	59	54	41	46	279	7.9

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
Source: Child Death and Serious Injury Review Committee database

For the ten year period between 2005 and 2014:

- ***The death rate for all deaths attributed to external causes showed a 7% decrease on average per year (p=0.001)***
- ***Thirty-nine percent of deaths attributed to external causes were due to transport incidents, 16% to accidents and 14% to suicide***
- ***Male children had a higher death rate than female children.***

Figure 8: External causes of child death by age and cause of death, South Australia 2005-14

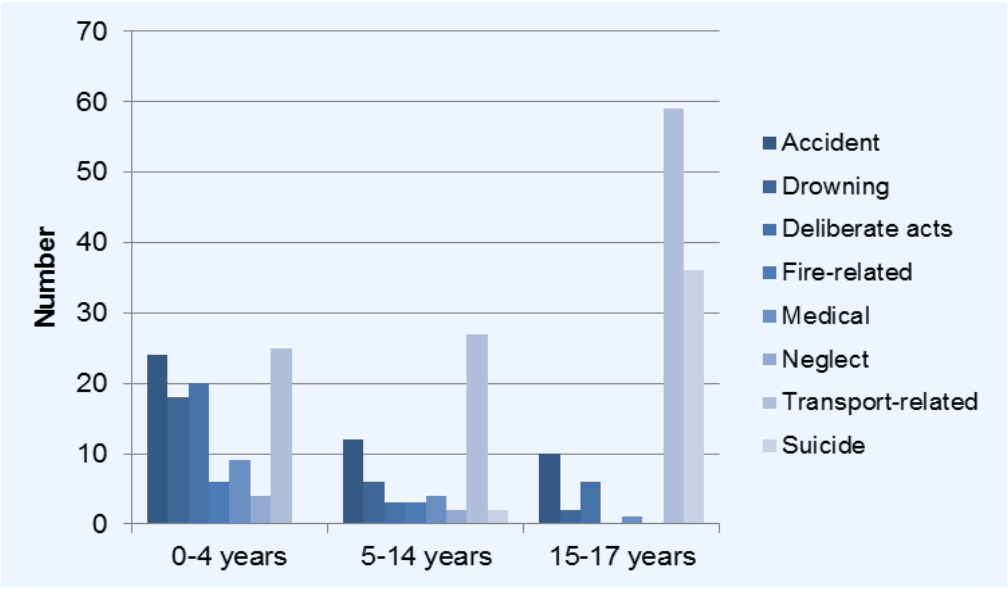
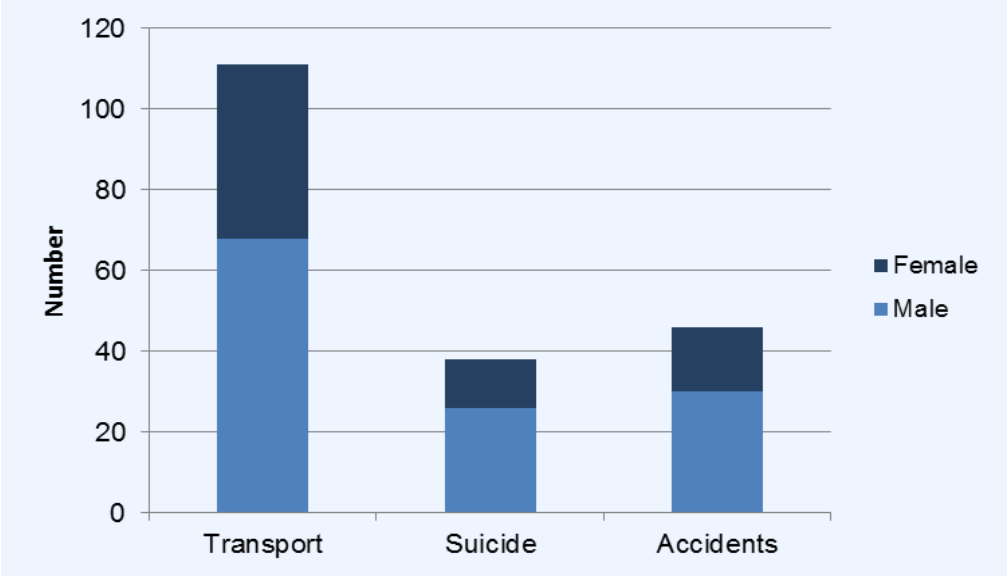


Figure 9: Transport, suicide and accidental death by sex, South Australia 2005-14



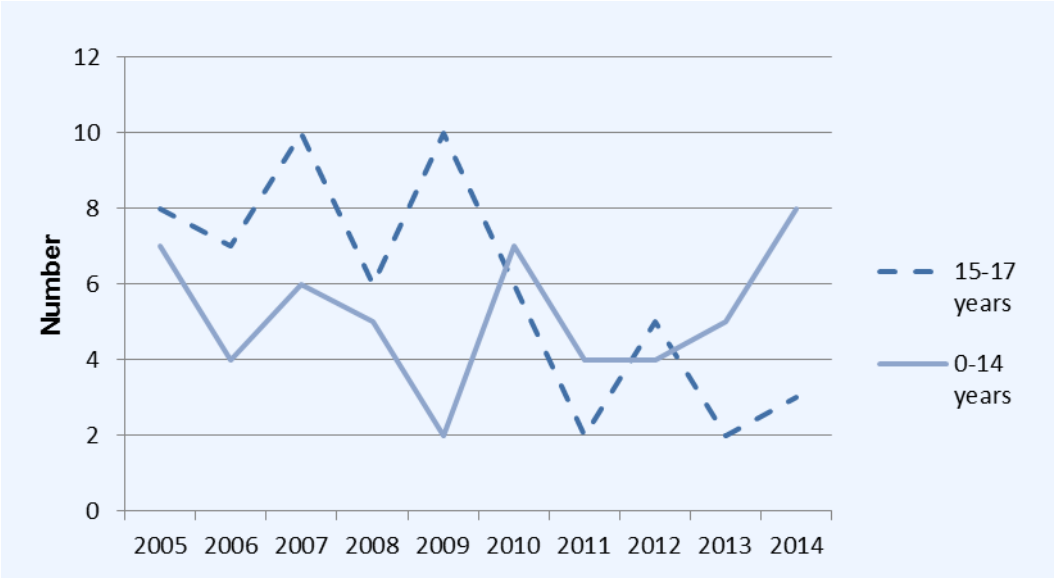
2.7.1. Transport deaths

In the ten year period between 2005 and 2014:

- One hundred and eleven deaths were due to transport incidents
- The death rate for all deaths attributed to transport incidents showed a 6% decrease on average per year (p=0.06). When only the deaths of 15 to 17 year olds attributed to transport incidents are considered, the death rate showed a 12% decrease on average per year (p=0.007)

- The majority of children aged 0-14 who died in transport crashes were passengers. Other circumstances of death for this age group were quad bike crashes, pedestrian deaths and low speed driveway rollovers
- Over half (59) of the deaths due to transport incidents were of young people aged 15-17 years. Two-thirds of these deaths were males
- Young Aboriginal people were at higher risk of death due to a transport incident than young non-Aboriginal people.

Figure 10: Transport deaths by age, South Australia 2005-14



2.7.2. Suicide deaths

In the ten year period between 2005 and 2014:

- Thirty-eight deaths were attributed to suicide, an average of almost four per year
- The death rate has fluctuated over individual years, but no trend was found (p = 0.2)
- Thirty-six deaths attributed to suicide were of young people aged 15-17 years
- Most suicide deaths resulted from hanging. Other causes included gun-shot wounds and overdose
- Sixty-eight percent of these deaths were males
- The majority lived in metropolitan (23) or inner regional (8) areas of the State.

2.7.3. Accidents

In the ten year period between 2005 and 2014:

- Forty-six deaths resulted from an accident
- One third of these deaths were infants younger than one year, who had been placed to sleep
- Over half of the deaths were males
- Aboriginal children were at higher risk of dying in accidents than non-Aboriginal children
- Almost half of these deaths were children whose family had had contact with Families SA
- Seventy percent of children dying as a result of an accident were living in areas of greatest disadvantage (SEIFA 4 and 5).

2.7.4. Deliberate acts

In the ten year period between 2005 and 2014:

- Twenty-nine deaths were attributed to a deliberate act
- Two-thirds (18) of the deaths attributed to a deliberate act were males
- Sixty-eight percent (20) of the deaths attributed to a deliberate act were children 0-4 years old
- Most children aged 0–4 years were killed by a parent. The perpetrator of the remaining deaths was unknown but in most cases the child was in the care of a parent or parent's partner at the time of their death
- Of the 20 deaths of 0-4 year olds, 45% (9) were from injuries associated with a fatal assault, four children died from stab wounds (all perpetrators were fathers) and the remaining eight from various deliberate acts including poisoning, drowning, suffocation and incineration.

2.7.5. Drowning

In the ten year period between 2005 and 2014:

- There were 26 drowning deaths
- Over half of these deaths were children aged 1-4 years.

Table 17: Demographics of child death attributed to external causes, South Australia 2005-14

	Number of deaths per year					Total	Rate[1] per 100 000 2005–14
	2005–06	2007–08	2009–10	2011–12	2013–14		
Total	**79**	**59**	**54**	**41**	**46**	**279**	**7.9**
Sex							
Female	37	19	20	15	19	110	6.4
Male	42	40	34	26	27	169	9.4
Age Group							
Infants (<1 year)	16	13	4	2	2	37	18.8[2]
1-4 years	19	10	14	11	15	69	9.1
5-9 years	8	4	3	6	4	25	2.6
10-14 years	10	6	6	3	9	34	3.4
15-17 years	26	26	27	19	16	114	18.4
Cultural Background							
Aboriginal	9	6	6	8	10	39	31.4
Contact with Families SA[3]							
Families SA	26	12	21	21	22	102	
Usual Residence							
Outside SA	7	3	2	2	4	18	
Socioeconomic Background (SEIFA IRSD)[4]							
Most disadvantaged SEIFA 5	20	22	19	12	16	89	10.1
SEIFA 4	19	11	11	9	7	57	7.4
SEIFA 3	15	9	12	8	6	50	8.2
SEIFA 2	13	6	6	7	8	40	6.2
Least disadvantaged SEIFA 1	5	8	4	3	5	25	4.1
Remoteness (ARIA)[4]							
Major City	43	36	25	23	24	151	6.0
Inner Regional	6	5	11	5	9	36	8.6
Outer Regional	10	8	13	10	7	48	10.7
Remote and Very Remote	13	7	3	1	2	26	20.1

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 Death rates for Families SA are not included. See Section 4.16.
4 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

2.8. Child death attributed to illness or disease

Table 18: Demographics of child death attributed to illness or disease, South Australia 2005-14

	Number of deaths per year					Total	Rate[1] per 100 000 2005–14
	2005–06	2007–08	2009–10	2011–12	2013–14		
Total	**151**	**155**	**160**	**144**	**138**	**748**	**21.3**
Sex							
Female	80	56	65	73	58	332	19.3
Male	71	99	95	71	80	416	23.1
Age Group							
Infants (<1 year)	108	110	111	96	98	523	265.3[2]
1-4 years	16	16	14	14	14	74	9.7
5-9 years	10	11	7	15	11	54	5.7
10-14 years	8	7	15	11	11	52	5.2
15-17 years	9	11	13	8	4	45	7.3
Cultural Background							
Aboriginal	14	15	11	15	19	74	59.6
Contact with Families SA[3]							
Families SA	28	32	30	29	19	138	
Usual Residence							
Outside SA	15	12	5	8	12	52	
Socioeconomic Background (SEIFA IRSD)[4]							
Most disadvantaged SEIFA 5	35	43	49	46	37	210	23.7
SEIFA 4	36	33	39	26	23	157	20.3
SEIFA 3	28	31	32	29	28	148	24.3
SEIFA 2	18	19	22	21	18	98	15.3
Least disadvantaged SEIFA 1	19	17	13	14	20	83	13.8
Remoteness (ARIA)[4]							
Major City	88	103	110	88	91	480	19.1
Inner Regional	20	16	17	15	12	80	19.1
Outer Regional	22	15	24	28	19	108	24.1
Remote and Very Remote	6	9	4	5	4	28	21.6

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 Death rates for Families SA are not included. See Section 4.16.
4 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

Causes of child death attributed to illness or disease include infections, cancer, diseases of the nervous system (eg. epilepsy) and the respiratory system (eg. asthma). Also included are deaths arising from conditions associated with pregnancy, labour and birth, and from congenital conditions such as heart malformations or chromosomal abnormalities. Some of these conditions are associated with chronic ill health which increases vulnerability to infections such as pneumonia. Other conditions are associated with medical or surgical interventions that increase vulnerability to secondary illnesses such as sepsis.

In the ten year period between 2005 and 2014:

- ***The death rate due to illness and disease has fluctuated over individual years but no trend was found (p=0.2)***
- ***Children younger than one year had a higher rate of death from illness and disease than older children***
- ***Male children had a higher death rate than female children***
- ***Aboriginal children were three times more likely to die from illness and disease than non-Aboriginal children***
- ***One hundred and thirty-eight children who died from illness or disease, or their families, had contact with Families SA (18%) in the three years before death***
- ***Children who lived in areas of greater disadvantage had a higher rate of death from illness and disease than those who lived in areas of least disadvantage.***

2.9. Child death and ICD-10 coding

Deaths have also been coded using the World Health Organization's (WHO) international Classification of Diseases (Version 10: ICD-10). Using this coding system, the underlying cause of death is considered the primary cause of death for classification.[27]

[27] *WHO ICD-10 Second Edition, 2005, 4. Rules and guidelines for mortality and morbidity coding. http://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf?ua=1*

Table 19: Child death by ICD-10 chapter, South Australia 2005-14

ICD-10 Chapter Description	Number of deaths per year					Total	Rate[1] per 100 000 2005–14
	2005-06	2007-08	2009-10	2011-12	2013-14		
Illness or Disease (Natural Causes)							
Certain infections and parasitic diseases (A00-B99)	4	2	8	4	1	19	0.5
Neoplasms (C00-D48)	18	19	10	17	14	78	2.2
Endocrine, nutritional and metabolic diseases (E00-E90)	6	5	6	7	4	28	0.8
Diseases of the nervous system (G00-G99)	16	12	23	9	15	75	2.1
Diseases of the eye and adnexa (H00-H59)	1	0	0	0	1	2	0.06
Diseases of the circulatory system (I00-I99)	4	4	6	6	5	25	0.7
Diseases of the respiratory system (J00-J99)	5	3	8	5	3	24	0.7
Diseases of the digestive system (K00-K93)	2	1	0	1	0	4	0.1
Diseases of the musculoskeletal system and connective tissue (M00-M99) or genitourinary system (N00-N99)	2	1	1	0	2	6	0.2
Certain conditions originating in the perinatal period (P00-P96)	65	71	63	63	66	328	9.3
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	41	38	37	30	29	175	5.0
Illness or Disease - Total	**164**	**156**	**162**	**142**	**140**	**764**	**21.7**
SIDS and Undetermined Causes Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	**18**	**19**	**24**	**17**	**15**	**93**	**2.6**
External Causes							
Transport-related (V01-V99)	28	29	24	16	17	114	3.2
Falls (W00-W19)	1	2	1	2	1	7	0.2
Exposure to inanimate mechanical forces (W20-W49)	2	4	1	0	4	11	0.3
Accidental drowning and submersion (W65-W74)	6	4	5	6	2	23	0.7
Other accidental threats to breathing (W75-W84)	9	7	5	7	2	30	0.9
Exposure to smoke fire and flames (X00-X09) and electrical transmission lines (W85)	2	0	1	1	3	7	0.2
Accidental poisoning by exposure to noxious substance (X40-X49)	1	3	1	2	2	9	0.3
Accidental exposure to other unspecified factors (X58-X59)	0	0	2	0	0	2	0.06
Intentional self harm (X60-X84)	3	2	8	2	10	25	0.7
Assault (X85-Y09)	9	4	5	4	2	24	0.7
Event of undetermined intent (Y10-Y34)	6	2	1	0	0	9	0.3
Medical devices associated with adverse incidents (Y70-Y82)	0	1	0	3	0	4	0.1
External Causes - Total	**67**	**58**	**54**	**43**	**43**	**265**	**7.5**
Cause not yet known	0	0	0	0	5	5	
All Deaths – Total	**249**	**233**	**240**	**202**	**203**	**1127**	**32.0**

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
Source: Child Death and Serious Injury Review Committee database

Section Three

Committee matters

S52W – Committee's reporting obligations

2) The Committee must, on or before 31 October of each year, report to the Minister on the performance of its statutory functions during the preceding financial year.

Children's Protections Act, 1993

3. Committee matters

3.1. Legislation and purpose

The Child Death and Serious Injury Review Committee was established by the Children's Protection Act, 1993 (the *Act*) in February 2006. It was an initiative arising from recommendations made in *Our best investment: a State plan to protect the interests of children* (Layton, 2003). An interim committee operated under directions issued by Cabinet from April 2005 until February 2006.

The role of the Committee is to contribute to the prevention of death or serious injury to children in South Australia.

The Committee reviews the circumstances and causes of death or serious injury to children and makes recommendations to Government that may help prevent similar deaths or serious injuries. Recommendations suggest changes in legislation, policies, procedures or practices.

3.2. Committee matters 2014 - 15

The Committee met ten times in 2014-15. Each member belongs to one of the four screening teams (see Figure 6) and each of these teams met as required.

In 2014-15, two new members were appointed to the Committee: Dr Deepa Jeyaseelan and Dr Mark Fuller. Their knowledge and expertise, in paediatrics, public health, alcohol and drug use and the mental health of children and young people, will add depth to the Committee's consideration of deaths.

The Committee continued to work across the following areas:

- The timely and accurate collection of information about the circumstances and causes of child deaths and serious injuries.
- Screening the circumstances and cause of each child death in South Australia and identifying systemic issues which should be addressed through the review process.
- Undertaking reviews of deaths and serious injuries to identify systemic issues and making recommendations to the Minister about systemic changes that will contribute to the prevention of similar deaths or serious injuries.

- Monitoring the progress of recommendations including supporting and contributing to prevention-based activities concerning child deaths and serious injuries.
- Contributing, through its Annual Report, to Government and community knowledge and understanding of the causes of child deaths and serious injuries, and the efforts that should be made to prevent or reduce deaths or serious injuries.
- Reporting to the Minister on the performance of its statutory functions.
- Maintaining links with interstate and national bodies undertaking similar work.

3.3. Governance and support

The Committee reports to the Minister for Education and Child Development who has responsibility for the administration of the *Act*. The Chair has met with the Honorable Susan Close MP on a number of occasions since her appointment as Minister for Education and Child Development in February 2015.

The Committee's administrative, financial and human resource management is overseen by the Department for Education and Child Development. The Committee was supported by:

Dr Sharyn Watts	Executive Officer
Ms Rosemary Byron-Scott	Senior Project Officer (P/T)
Ms Una Sibly	Senior Project Officer (P/T from Oct 2014)
Ms Miranda Furness	Senior Project Officer (P/T from May 2015)
Ms Melanie Kydd	Administration and Information Officer (until Sept 2014)
Ms Claire Aberlé	Administration and Information Officer (from May 2015)

3.3.1. The Premier's 2014 review of Boards and Committees

In July 2014, Premier Weatherill announced his intention to abolish every South Australian Board and Committee unless it could be demonstrated that it had an essential purpose that could not be met through other means. The Committee provided a submission about its purpose and function to The Minister for Education and Child Development and in October 2014, the Premier informed the Chair that the Child Death and Serious Review Committee would be retained in its current form.

3.4. Supporting prevention through partnerships

3.4.1. The Committee's 100th meeting

In 2014, the Committee hosted an event which acknowledged its 100th meeting since its establishment. The event theme 'Help us make each story count' reflected the Committee's view that, although tragic in themselves, there is much that can and should be learned from the careful review of a child's death.

The Honorable Robyn Layton AO QC who first recommended the establishment of a child death review committee in South Australia, spoke at this event, as did the then Minister for Education and Child Development, the Honorable Jennifer Rankine MP. Premier Weatherill, through a taped address, thanked present and former committee members and acknowledged the significant role the Committee had played in many different areas including infant safe sleeping, water safety, youth suicide and child protection matters.

Over 50 people representing government and non-government agencies, university departments and, former Committee members attended this event. The Committee's Chair thanked those present for their support and acknowledged the contribution of all of those who had worked with the Committee to improve the safety and wellbeing of children in South Australia.

3.4.2. The Kidsafe SA Inaugural Helen Noblett Award

On 24 October 2014, National Kidsafe Day, the Committee was delighted to receive one of three Kidsafe SA Inaugural Helen Noblett Awards. This award recognised the Committee's contribution to the prevention of childhood injury in South Australia. The event was held at the Women's and Children's Hospital and was attended by three generations of the late Helen Noblett's family.

3.4.3. The Australian and New Zealand Child Death Review and Prevention Group

Each year since 2006, the Chair and/or Executive Officer has represented the Committee at the national meeting of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). Responsibility for chairing this group passes from one jurisdiction to another every three years. For the years 2015-18, this

Committee will be responsible for chairing the ANZCDR&PG. Funding to support this work has been provided by the Minister for Education and Child Development.

3.4.4. Sharing knowledge

In 2014-15 Committee members or members of the Secretariat have made the following presentations:

- 'Understanding the challenges for South Australian Aboriginal families and children: What can child death review processes contribute?' and 'Issues for Australian children with a disability and their families: What mortality statistics tell us.' Papers presented to the 13th Australian Institute of Family Studies Conference, August 2014
- A short article based on the first paper above has been submitted for publication on the AIFS website and is under review pending publication
- Prevention of youth suicide – panel discussion, 4th Australasian Conference on Child Death Inquiries and Reviews, Perth November 2014
- Suicide prevention and young people – Department of Education and Child Development's social work practitioners.

Section Four

Methodology

4. Methodology

4.1. Deaths included in the Annual Report

In Section 2 the numbers of deaths referred to are based on the calendar year: 1 January 2014 to 31 December 2014. Reporting by calendar year is consistent with the practices of the Australian Bureau of Statistics (ABS) and child death review teams in other states and territories.

The date of death is used as the marker for its inclusion in the data set for that year.

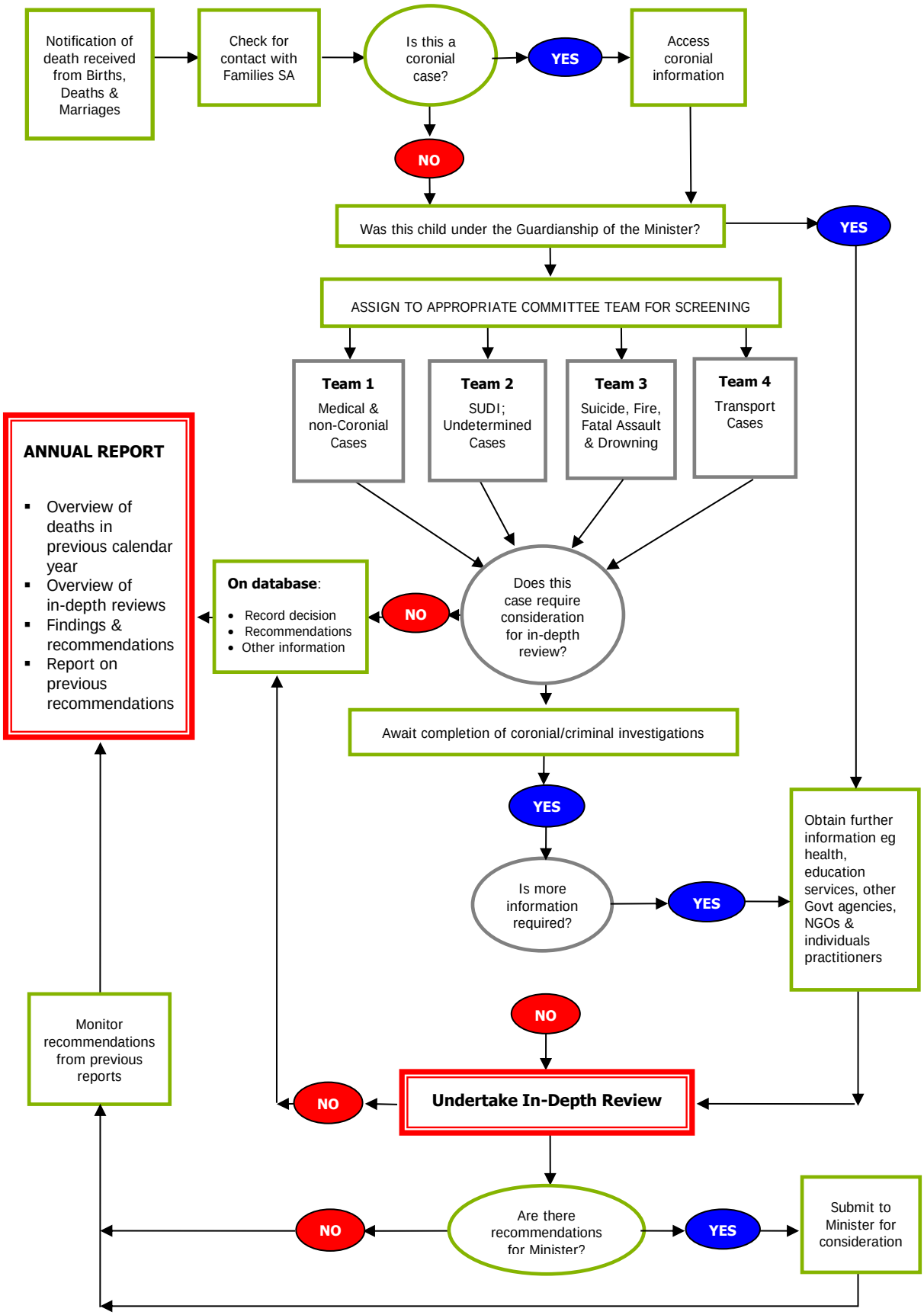
The number of deaths the Committee reports on each year is based on information received from the Office of Births, Deaths and Marriages. In 2013 the Committee determined that the following deaths would be excluded from the annual report:

- Where the death of an infant occurred after a genetic termination of pregnancy as recorded in the Perinatal Death Certificate; or
- Where the death occurred after the spontaneous birth of an infant prior to 20 weeks gestation.

4.2. Access to information and the process for screening and review of deaths

Figure 6 indicates the key sources of information available to the Committee about the deaths of children in South Australia and illustrates the processes the Committee uses to screen and review this information.

Figure 11: Committee's Screening and Reviewing Process



4.3. The Office of Births, Deaths and Marriages

The Committee currently has a protocol with the Office of Births, Deaths and Marriages for the release of information about the deaths of children in South Australia. This information is provided to the Committee on a monthly basis.

4.4. The Office of the State Coroner

Under an arrangement with the Coroner, information is released to the Committee for each reportable death of a child aged under 18 years of age.

A further protocol outlines the exchange of information between the Committee and the Domestic Violence Research Officer, attached to the Coroner's Office.

4.5. Release of information from Government agencies

The Committee has protocols with SA Health and the Department for Education and Child Development, which includes Families SA, regarding release of information.

A further protocol outlines the exchange of information between the Committee and the SA Health Maternal and Perinatal Mortality Committee.

4.6. In-depth review process

Deaths screened by the Committee are assigned one of the following criteria:

- Not eligible for review - a case will be considered ineligible for review under s52S (2) of the *Act* – if the child was not normally resident in the State at the time of death or serious injury or the incident resulting in death or serious injury did not occur in the State
- Not for review - a case may not require in-depth review if the screening of information available at the time indicates that there are no systemic issues arising from the death. These cases are assigned a category of death eg illness or disease, SUDI, transport, deliberate acts etc. and the details are kept on the Committee's database until required for inclusion in the relevant Annual Report. These cases may be included in reviews in later years where features from cases over a number of years suggest that there may be systemic issues that can be addressed

- Pending further information - in some cases the Committee requests further information prior to making a decision regarding in-depth review. The majority of cases awaiting further information are deaths attributed to illness or disease or health-system-related adverse events. The medical screening team maintains a high level of scrutiny regarding the circumstances of the deaths of children from these causes, especially where children have received health services, have had complex conditions requiring a high level of care, or where there has been an interface between medical, welfare and other systems
- Pending completion of investigations - in accordance with Section 52S (4) of the *Act*, the Committee must ensure that its review processes will not compromise criminal or coronial investigations before it undertakes a review. Criminal investigations are considered to be concluded once any person involved in the death or serious injury of the child has been sentenced, or once South Australia Police have determined they have no further interest in the matter. Investigations conducted by the Coroner are considered to have ended when the Coroner has made a finding into the cause of death or a coronial inquest has been completed
- Awaiting assignment - in any reporting year, there are also cases ready for review but awaiting assignment of a 'review team' to undertake the review.

The number of cases pending investigation or review gradually decreases in any year, as information is obtained, cases are finalised in the criminal and coronial systems, and the Committee makes a determination about further review and undertakes this review.

4.7. Reporting requirements

Section 52W of the *Act* outlines the reporting responsibilities of the Committee. It requires the Committee to report periodically to the Minister for Education and Child Development, and also to provide an annual report on the performance of its statutory functions during the preceding financial year.

The Committee submits a report to the Minister for Education and Child Development at the conclusion of each in-depth review. The report contains the Committee's recommendations about systemic issues that may contribute to the prevention of similar deaths or serious injuries.

4.8. The Committee's classification of cause of death

In Section 2 *Child deaths South Australia 2005-14,* the Committee's classification of the cause of death has been used. In many cases, the Committee has multiple sources of information available about children (including health, welfare and education records) and is not limited to the causes of death recorded in post-mortem reports or death certificates. Accordingly, the Committee's classification for a particular death may vary from the ICD-10 classification. See Section 2.9 *Child death and ICD-10 Coding* for an explanation of this coding.

At the time of classifying a death, the Committee will consider all available information. However in some cases, further information may become available that may give rise to a change in the classification assigned to a particular death or group of deaths. Any changes will be noted as an addendum in the subsequent Annual Report. In addition, the Committee will continue to review its definitional guidelines in the light of available information.

The guidelines the Committee uses to classify deaths from external causes are described below.

4.8.1. Transport deaths

Transport deaths include deaths resulting from incidents involving a device used for, or designed to be used for, moving people or goods from one place to another. These incidents may involve pedestrians and include railway or water transport. Incidents may occur on public roads or places other than a public road.

4.8.2. Accidents

Accidents exclude deaths attributed to transport incidents, fires or drowning. Also referred to as deaths from unintentional injuries, these deaths most commonly include accidental: suffocation, strangulation and choking, falls and poisoning.

4.8.3. Suicide

The Committee's definition of suicide is:

Taking one's own life, intending to do so.

The Committee defines a death as suicide if, after a thorough review of all available evidence, it is satisfied that the young person killed him or herself intending to take their own life.

Since adopting this definition, three cases previously attributed to suicide have now been reclassified as accidental deaths, resulting from misadventure.

4.8.4. A deliberate act by another causing death

In previous years one of the categories of death due to external causes was known as 'fatal assault.' A 'fatal assault' was defined as 'the death of a child from acts of violence perpetrated upon him or her by another person'.[28]

From time to time cases were included in that category which did not really fit the definition of a fatal assault. For instance, a death caused by the deliberate administration of a drug to a child without any intention of causing the child's death.

Accordingly the Committee considered that a category known as 'a deliberate act by another causing death' better described a range of deaths, including deaths from acts of violence, where a person, by whatever means, causes a child's death by a deliberate act.

It is the Committee's view that a simple definition avoids the sorts of complications that would inevitably arise if one sought to establish the intent of the person whose deliberate act results in a child's death. For instance in the example of the deliberate administration of a drug to a child, the person's intent could be to medicate the child.

Other examples might include hitting a young child to quieten them, but in such a way that death ensued. Of course in more extreme cases the person's intent might well be to seriously injure or indeed kill the child.

While a person's intent is obviously relevant to issues of criminal liability, for the Committee's categorisation of deaths this does not need to be considered.

Similarly, there may be cases where the person who causes a child's death does so as a result of mental illness, leading to a Court finding of mental incompetence. Such cases are also included in this category.

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[28] *Lawrence, R. (2004) Understanding fatal assault of children: a typology and explanatory theory. Children and Youth Services review, 26, 841-856.*

It will not always be possible, on the basis of the available evidence, to be certain that a child's death resulted from a deliberate act by another person. For instance a child may have serious head injuries causing death but it is not possible to say that the injuries were deliberately inflicted as opposed to being caused by an accidental fall.

In such cases, upon consideration of all the available evidence, the Committee will decide which is the most likely cause of death.

4.8.5. Neglect

The Committee defines neglect as 'a death resulting from an act of omission by the child's carer(s)' including:

- Failure to provide for the child's basic needs
- Abandonment
- Inadequate supervision, and
- Refusal or delay in provision of medical care.

This definition can account for both chronic neglect and single incidents of neglect, or a combination of both.[29]

4.8.6. Health system-related adverse events

These deaths have been classified as such by the Committee based on written records which may not necessarily be complete. The Committee places a death in this category based on consideration of preventable aspects in the circumstances of the death and a focus on future prevention strategies rather than an investigation of the cause of death.

4.8.7. Sudden Unexpected Death of Infants (SUDI) and Sudden Infant Death Syndrome (SIDS)

Sudden unexpected death in infancy (SUDI) has been described as an 'umbrella' term that is used for all sudden unexpected deaths of infants younger than one year of age.

[29] *Lawrence, R. & Irvine, P. Redefining fatal child neglect. Child Abuse and Prevention, 21, 1-22.*

The definition of Sudden Unexpected Death in Infancy (SUDI)

In December 2007 the Australian and New Zealand national meeting of child death review teams and committees agreed to work towards a common reporting framework that was based on the definition of SUDI proposed by Fleming et al. (2000).[30] The agreed SUDI definition is: Infants from birth to 365 completed days of life whose deaths:

Criterion 1 Were unexpected and unexplained at autopsy;

Criterion 2 Occurred in the course of an acute illness that was not recognised by carers and/or by health professionals as potentially life-threatening;

Criterion 3 Arose from a pre-existing condition that had not been previously recognised by health professionals; or

Criterion 4 Resulted from any form of accident, trauma or poisoning.

The definition of Sudden Infant Death Syndrome (SIDS)

The criteria used to determine a death attributed to SIDS continues to be the San Diego definition proposed by Krous et al. (2004, see Table 20). Death rates for SIDS are reported per 100 000 livebirths.

[30] *Fleming, P., Bacon, C., Blair, B. and Berry, P.J. (2000) Sudden unexpected deaths in infancy, the CESDI studies 1993-1996. London: the Stationary Office.*

Table 20: Definition of sudden infant death syndrome

General Definition of SIDS*

SIDS is defined as the sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.

Category IA SIDS: Classic features of SIDS present and completely documented

Category IA included deaths that meet the requirements of the general definition and also all of the following requirements.

Clinical

- > 21 days and < 9 months of age;
- Normal clinical history including term pregnancy (gestational age > 37 weeks);
- Normal growth and development;
- No similar deaths among siblings, close genetic relatives (uncles, aunts or first degree cousins), or other infants in the custody of the same caregiver).

Circumstances of Death

- Investigations of the various scenes where incidents leading to death might have occurred and determination that they do not provide an explanation for the death;
- Found in a safe sleeping environment, with no evidence of accidental death.

Autopsy

- Absence of potentially fatal pathologic findings. Minor respiratory system inflammatory infiltrates are acceptable; intrathoracic petechial haemorrhage is a supportive but not obligatory or diagnostic finding;
- No evidence of unexplained trauma, abuse, neglect or unintentional injury;
- No evidence of substantial thymic stress effect (thymic weight < 15g and/ or moderate/severe cortical lymphocyte depletion). Occasional 'starry sky' macrophages or minor cortical depletion is acceptable;
- Negative results of toxicologic, microbiologic, radiologic, vitreous chemistry and metabolic screening studies.

Category IB SIDS: Classic features of SIDS present but incompletely documented

Category IB includes infant deaths that meet the requirements of the general definition and also meet all of the criteria for category IA except that investigation of the various scenes where incidents leading to death might have occurred was not performed and/ or >1 of the following analyses were not performed: toxicologic, microbiologic, radiologic, vitreous chemistry or metabolic screening studies.

Category II SIDS

Category II includes infants that meet category I except for > 1 of the following.

Clinical

- Age range outside that of category IA or IB (ie 0-21 days or 270 days (9 months) through to first birthday);
- Similar deaths among siblings, close relatives or infants in the custody of the same caregiver that are not considered suspect for infanticide or recognised genetic disorders;
- Neonatal or perinatal conditions (eg those resulting from pre-term birth) that have resolved by the time of death.

Circumstances of Death

- Mechanical asphyxia or suffocation caused by overlaying not determined with certainty.

Autopsy

- Abnormal growth or development not thought to have contributed to death;
- Marked inflammatory changes or abnormalities not sufficient to be unequivocal cause of death.

Unclassified sudden infant death

Includes deaths that do not meet the criteria for category I or II SIDS, but for which alternative diagnoses of natural or unnatural conditions are equivocal, including cases where autopsies were not performed.

Post resuscitation cases

Infants found in extremis who are resuscitated and later die ('temporarily interrupted SIDS') may be included in the aforementioned categories, depending on the fulfilment of relevant criteria.

*Krous, H. F., Beckwith, J. B., Byard, R. W., Rognum, T. O., Bajanowsky, T., Corey T., Gutz, E., Hanzlik, R., Keens, T. G. and Mitchell, E. A. (2004) Sudden infant death syndrome and Unclassified infant deaths: A definitional and diagnostic approach. Paediatrics, 114, 234 – 238.

4.9. Deaths of children with disability 1 – 17 years old

The definition used to determine inclusion as the death of a child with disability for children 1–17 years old is:

- The child was over one year of age at the time of death
- The child's daily activities were limited because of their disability, illness, disease or health problem, and
- The child's daily activities were adversely affected for a period of six months or more.

Where the length of time during which the child's daily activities were adversely affected was unknown, the case was not included on the Register.

Cases where the child had a chronic health issue (eg. asthma, epilepsy, diabetes) were only included on the Register if other disabilities were present.

Some children had multiple types of disability, for example cerebral palsy and epilepsy. Multiple disability diagnoses were recorded for each child when they were identified. The categories of disability used are provided below.

4.9.1. Neurodegenerative diseases, genetic disorders and birth defects

This category included all instances of neurodegenerative diseases, genetic disorders and birth defects, including in-born errors of metabolism where the child's health deteriorates over time.

Children with many of these conditions are likely to die as a result of their disease and they require significant care as their condition progresses.

4.9.2. Cerebral palsy

This category included all cases of cerebral palsy, which is a term used to describe a group of non-progressive motor function disorders that arise because of damage to, or dysfunction of, the developing brain. This permanent condition can affect body movement, muscle control, muscle coordination, muscle tone, reflex, posture and balance. It may also cause visual, learning, hearing, speech and intellectual impairments, as well as epilepsy.

4.9.3. Epilepsy

Using the guidelines developed to identify disability, this category only included cases where the frequency and severity of the child's epilepsy would have adversely affected their daily activities for a period of six months or more, or the child with epilepsy had associated disability.

Epilepsy is a common disorder that is characterised by recurring seizures or sudden, uncontrolled surges in the normal electrical activity in all, or part, of the brain. While the Epilepsy Centre notes that epilepsy can mostly be controlled by taking medication and restricting daily living activities, epilepsy can be associated with sudden unexpected death.

4.9.4. Heart and circulatory problems

This category included all cases where a condition involving the heart or blood vessels was able to be identified, regardless of whether the condition resulted from an infection or from a birth defect.

Children with conditions such as complex congenital heart defects or myocardiopathy are, without life-saving surgery such as a heart transplant, at higher risk of dying as a result of their heart or circulatory problems.

4.9.5. Intellectual disability

This category included all cases where the available information suggested that the child had some form of intellectual disability. It was identified as a specific category because it is a developmental disorder, and people living with such disorders have significantly more difficulty than others in integrating new learning, understanding concepts and solving problems.

4.9.6. Autism spectrum disorder

Autism Spectrum Disorder is a lifelong developmental disability that affects, among other things, the way a child relates to his or her environment and their interactions with other people. Where information was available indicating a diagnosis of ASD had been made, a child was placed in this category.

4.9.7. Other disability types

This category accommodated all of the remaining disability types in children on the Disability Register. It incorporated cases where the child had conditions such as Epstein-Barr virus, systemic lupus and community acquired pneumonia. It also included cases where the available information was too limited to confidently assign the case to a specified category.

4.9.8. Cancer and disabling medical conditions

Several approaches to the classification of cancers and other health conditions that may adversely affect a child's life for longer than six months have been taken by the Committee. In the 2012 Special Report on the deaths of children with disability, these deaths were included in the Disability Register. In 2013, these deaths were re-classified as 'disabling medical conditions' and no longer included in the Disability Register. In 2014, these deaths will not be reported on as deaths associated with disability and will only be reported as deaths from illness or disease. The Disability team considered that the issues arising from these deaths were primarily about the medical management of these conditions rather than about issues arising from the disability caused by their impact on the child.

4.10. Deaths of infants with a disability

There is a unique set of challenges associated with identifying disability in infants. A set of criteria have been developed by the Committee to identify the deaths of infants with a disability. Deaths are excluded from consideration if the underlying cause of death is:

- Prematurity alone
- Prematurity and maternal factors, or infection, haemorrhage, digestive or respiratory problems
- SIDS
- Undetermined or external causes of death
- Cancer
- Heart disease, including myocarditis and cardiomyopathy
- Congenital malformations of major organs such as heart, kidney and liver

Once these cases are excluded, the ICD-10 underlying cause of death code is cross-referenced against a list of ICD-10 Codes that the Disability Review team[31] has confirmed as representing disability. These codes had previously been identified with reference to the codes used to identify disabilities in the 1-17 year age group. The remaining deaths are then reviewed by the Disability team and a decision made about inclusion in the Disability register based on the available information.

4.11. Aboriginal and Torres Strait Islander Status

The information received from the Office of Births Deaths and Marriages has an Aboriginal or Torres Strait Islander indicator for each case. The Committee has determined that, in the absence of any other form of reliable indicator of ATSI status, this indicator will be used.

4.12. Deaths of children in contact with the child protection system

To be included in this section of the report, the child or a member of their family must have had some form of contact with Families SA within three years of the incident resulting in their death.

The guardianship status of a child or parent is determined during the process of checking each child and their family for contact with Families SA. A child or parent may have been under guardianship in another Australian State.

4.13. Usual place of residence

The information received from the Office of Births Deaths and Marriages indicates the 'last place of residence' of each child. This information is taken to indicate the child's usual place of residence for review and reporting purposes. The Committee acknowledges that this information may have been variously interpreted by the person giving the information, and may not reflect a consistent definition of a person's usual residence.

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[31] *The Disability Review team comprises three members of the Committee and includes a medical practitioner with in-depth knowledge about children with disability, a child psychologist and a social work consultant.*

Each Annual Report records the number of cases where the information from the Office of Births Deaths and Marriages shows that the child's last place of residence was outside South Australia.

4.14. ARIA+ Index of Remoteness and Accessibility

ARIA stands for Accessibility/Remoteness Index of Australia. The ARIA methodology was developed by the Australian Government Department of Health and Aged Care in 1977. Minor changes have been made to this original methodology, resulting in the ARIA+ index of remoteness. This Index is a distance-based measure of remoteness.[32] It defines five categories of remoteness based on road distance to service centres: *major city*, *inner regional, outer regional*, *remote* and *very remote*. The *very remote* category indicates very little accessibility to goods, services and of opportunities for social interaction. ARIA+ Index is an indicator of the degree of geographic remoteness of an area and is a more accurate indicator of disadvantage than subjective labels such as 'rural' or 'country'.

4.15. SEIFA Index of Relative Socio-economic Disadvantage

The SEIFA (Socio-Economic Indexes for Areas) Index of Relative Socio-economic Disadvantage (IRSD)[33] draws on a variety of personal and household characteristics (available from the 2006 Census) to rank household and socioeconomic status. The IRSD is calculated to show the relativity of areas to the Australian average for the particular set of variables which comprise it. This average is set at 1000. Scores below 1000 indicate areas with relatively disadvantaged populations under this measure, and scores above 1000 indicate areas with relatively advantaged populations. In this report SEIFA IRSD scores are divided into five quintiles, with the least disadvantaged populations represented in quintile 1 and the most disadvantaged in quintile 5. The SEIFA IRSD score and quintile assigned to a child's residential postcode was obtained from the Australian Bureau of Statistics reports 'Census of Population and Housing: Socio-Economic Indexes for Areas, Australia 2011[34] and 'Census of Population and

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[32] *AIHW (2004)* Rural, regional and remote health: a guide to remoteness classifications. *AIHW Cat no PHE 53, Canberra: AIHW http://aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459567 Accessed September 2014.*
[33] *ABS* SEIFA Indexes *2011 http://www.abs.gov.au/ausstats/abs@.nsf/mf/2033.0.55.001*. Accessed September 2014.
[34] *Australian Bureau of Statistics 2013, Census of Population and Housing: Socio-Economic Indexes for Areas, Australia, 2011, datacube: cat. no.2033.0.55.001,*

Housing: Socio-Economic Indexes for Areas, Australia 2006'.[35] For the death years 2005-2008 in this Report the 2006 Census estimate is used, and for 2009-12 the 2011 Census is used.

4.16. Death rates

Death rates have been calculated using Australian Bureau of Statistics (ABS) population projections. In the period 2005 to 2014 the estimated number of resident South Australian children aged 0-17 years was 3 518 767.[36] Children who died in South Australia but whose usual residence was outside of the State are included in all calculations except the death rates of only those children resident in the State at the time of death.

The death rates for Aboriginal children were calculated using the Estimated Resident population of South Australian Aboriginal children aged younger than 18 years. (12 551 Aboriginal children – 2011 Census).[37]

The Infant Mortality Rate (IMR) is calculated according to the deaths of children younger than one year old per 1000 live births in the same year. For the purpose of comparison in the tables in this report, the IMR is represented as the deaths of children younger than one year old per 100 000 live births in that year. The South Australian Maternal, Perinatal Mortality Committee provided data about live births. Between 2005 and 2014 there were 197 144 live births in South Australia (provided as provisional data on 17 September 2015).

The rates of death for children whose families have had contact with Families SA are calculated by dividing the number of children dying whose families had contact with Families SA by the total population of children in SA. The Committee defines 'contact with Families SA' to be any recorded contact in the three years prior to the child's death. It would be preferable to use the denominator 'all children whose family had had contact with Families SA' to calculate the death rate as this would enable a comparison of the rate of death for children whose family had had contact with Families

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http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2033.0.55.001~2011~Main%20Features~Main%20Page~1, Accessed 14 September 2015,

[35] *Australian Bureau of Statistics 2008, Census of Population and Housing: Socio-Economic Indexes for Areas, Australia, 2006, datacube: cat. no.2033.0.55.001, Accessed 14 September 2015, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2033.0.55.0012006?OpenDocument*

[36] *Australian Bureau of Statistics (2012)* Australian Demographic Statistics *http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Mar%202014?OpenDocument Accessed September 2015*

[37] *Advice received from Public Health Information and Development Unit, University of Adelaide, September 2010. Australian Bureau of Statistics. Table Builder https://www.censusdata.abs.gov.au/webapi/jsf/selectTopic.xhtml Accessed October 2014*

SA and those who had not. However, this information about the number of children who had contact with Families SA from 2005-12 is not readily available. A prevalence rate only is presented in this report for the purposes of comparison over time of the death rates of children whose families have been in contact with Families SA.

Death rates within SEIFA quintiles are calculated using the total number of children aged 0-17 years in each SEIFA quintile. This information is provided by the ABS.[38]

Death rates within the Accessibility/Remoteness Index of Australia (ARIA) categories are calculated using the total number of children aged 0-17 years in each ARIA category. This information is provided by the ABS.[21]

The Poisson distribution is used to investigate whether there are trends in the number of deaths due to various causes. The Poisson distribution describes the occurrence of rare events. A p-value of less than 0.05 denotes a significant increasing or decreasing trend.

4.17. Mapping

South Australian government departments and agencies have developed a consistent set of boundaries to define twelve administrative regions in the State. The relevant government region is assigned to each child's residential postcode.[39] Rates in each region are calculated using the following formula: the sum of child deaths in each postcode within a region divided by the sum of the total population of children in the postcodes within each region. This information is used to generate maps of the distribution of child deaths within the State.

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[38] *Personal Communication 18 September 2015, Regional Population Unit, Demography, Australian Bureau of Statistics*

[39] *https://www.sa.gov.au/topics/housing-property-and-land/building-and-development/land-supply-and-planning-system/south-australian-government-regions Accessed 20 October 2015*